



National American Indian & Alaska Native

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**Secondary
Trauma: How
Providers Can
Cope**



DIRECTOR'S CORNER



Welcome to the National American Indian and Alaska Native Prevention TTC's summer issue of the newsletter focused on Secondary Trauma. We decided to focus this issue of our newsletter on secondary trauma and compassion fatigue because the COVID-19 pandemic has brought up historical and inter-generational trauma, both in our patients and in ourselves as providers. These three months have been exhausting for behavioral health providers, first line/essential health care/prevention and treatment providers. In addition, in tribal and urban Indian communities, providers are not insulated from experiencing the loss of family members and friends, nor from getting ill themselves. Such challenges take a toll on people and often leads to exhaustion and compassion fatigue, which is our main topic for this newsletter issue.

One of our colleagues who has focused her career on trauma, trauma-informed care, and trauma-informed prevention strategies is Dolores S. Bigfoot, Professor in the Center on Child Abuse and Neglect at the University of Oklahoma College of Medicine. Professor Bigfoot is the director of the Indian Country Child Trauma Center, and we have included an interview discussing her important work.

We also recently focused our webinar series on trauma, including sessions in June presented by Dr. Wendee Gardner and Elizabeth Neri on the topic of [*Building Resilience in Our Patients, Communities, and Ourselves in a Time of COVID-19: Lessons for Behavioral Health Providers*](#), and in May we held back-to-back sessions with Dr. Beth Boyd, who presented [*Historical Trauma: Definition, Impact, and Hope for Healing*](#); and Dr. Wendee Gardner and Dr. Danica Love Brown, who presented [*Trauma, Adverse Childhood Experiences, and Their Impacts on the Health and Wellbeing of Native American & Alaska Native People*](#). Links will bring you to recordings of those sessions.

The COVID-19 pandemic has changed the world for most of us, and brought up many questions about how to do the work of prevention in these circumstances. For that reason we decided to offer weekly listening sessions beginning in April titled: Connecting Prevention Specialist to Native Communities during Times of Crisis. This program has been a successful collaboration between our Prevention TTC and the SAMSHA Tribal Training and Technical Assistance Center. The themes for these sessions have been suggested by participants to ensure that themes are important and relevant for their work as prevention specialists. In honor of Pride Month, we also recently focused one of our sessions on specific Native LGBTQ+ and Two Spirit issues in developing prevention programs.

We have many ongoing and upcoming programs that will now be offered online, including: 1) Developing Health Promotion Campaigns focused on supporting tribal and urban Indian prevention specialists, and accompanied by a 6-month virtual learning collaborative; 2) Screening, Brief Intervention, and Referral to Treatment (SBIRT) training in times of a public health crisis, 3) Wellness series with four sessions on self-care and coping with grief and stress, and finally 4) Let's connect Training for Family Providers: Building best practices for youth and families, starting June 29. In addition, the center's fourth culture card will be completed and published in July: *Engaging Tribal Leaders and other Stakeholders for Prevention Efforts*.

We are engaged in many programs that we have developed because of input from our stakeholders and collaborators like you, our reader. Our relationship with you is very important, so let us continue to hear from you, and we will do our best to develop programs to meet your needs.

Stay safe and healthy.

Anne Helene Skinstad, PhD
Program Director



SECONDARY TRAUMA: THE UNINTENDED CONSEQUENCE OF TRAUMA

KEN C. WINTERS, PhD

contributions from MARY K. WINTERS, MEd

Introduction

Secondary trauma is a pattern of psychological symptoms that approximates the symptoms of posttraumatic stress disorder (PTSD) and occurs in professionals who research trauma, who work directly with or counsel individuals who have experienced trauma, or in the general population as a result of an indirect experience with trauma.^{1,2} The effects, which can be “disruptive and painful” and can “persist for months or years,”³ are considered a usual response which results from the transference, or rippling-out effects, of trauma from the original incident and the original victim or survivor to another person, typically a trauma worker. The original victim may have personally experienced the trauma or has knowledge about such an event.³ Assessment tools are available to assess secondary trauma, although most are designed for trauma workers rather than the general population.^{4,5}

The research literature uses a number of interchangeable terms to refer to secondary trauma, such as vicarious trauma and compassion fatigue.⁶ The American Counseling Association describes secondary trauma as the “emotional residue of exposure,”⁷ and the DSM-5⁸ acknowledges that stress-related symptoms may be associated with individuals indirectly exposed to trauma.⁹

Is burnout a form of secondary trauma? Burnout, which is typically aligned with the negative effects of heavy work demands (e.g., balancing caregiving and work; long hours), rather than the specific nature of work involved. Secondary trauma may overlap with burnout; in a meta-analysis analyzing data of 8,256 workers who experienced secondary traumatic stress as part of their occupation, researchers found there was high correlation between job burnout and stress related to secondary trauma.^{10,11,12} But secondary trauma is distinguishable from job burnout in that the former is linked to the stress and negative emotions resulting from work related to trauma.



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Secondary trauma stress (STS), sometimes referred to as compassion fatigue, is viewed as a consequence of secondary trauma. STS is manifested by the incidence or prevalence of various stress reactions related to indirect contact with trauma.^{10,30} Examples of those who may experience STS include funeral directors, victim advocates, attorneys, jurors, court workers, and journalists.¹⁰ Professionals who work therapeutically with trauma victims have elevated risk for STS as a function of trauma caseload volume.⁹

Prevalence

What is the extent to which health workers develop secondary trauma or its symptoms? Ivicic and Motta¹³ assessed 88 psychologists, social workers, mental health counselors, and creative arts therapists, who completed an objective measure of secondary trauma. Study results revealed that between 23 and 27% of respondents were positive for secondary traumatization. Those with a history of trauma exposure reported a higher rate of secondary trauma, but no relationship was found for level of trauma exposure, quality of supervision, and job satisfaction. A second systematic study examined a large sample of child welfare caseworkers (N = 1968) in three states.¹⁴ Results indicated relatively high levels of secondary trauma, with 29.6% of caseworkers scoring in the “severe” range. Predictors of secondary trauma were reports of job burnout and lack of organizational support. Yet use of coping strategies were protective; the more effective copers were most likely to have a clear self-care plan, participate in activities or hobbies, and have a work-to-home transition plan.

Professions Impacted by Secondary Trauma

Although it has been observed that negative vicarious impacts may occur among anyone in the general population, there is substantial attention in the research literature on front-line health providers, emergency responders, police officers, military personnel, and people counseling those who have experienced trauma.^{15,16} More recently, this has been expanded to include humanitarian workers, social workers, suicide helpline workers, funeral directors, a wide range of healthcare professionals (including victim advocates), justice system professionals, journalists, and faith leaders.^{17,18,19} As we discuss below, Native American and Alaska Native people may also suffer from secondary trauma as a result of historical trauma.

Historical Trauma

According to Dr. Maria Yellow Horse Brave Heart, historical trauma is the “cumulative emotional and psychological wounding over one’s lifetime and from generation to generation following loss of lives, land and vital aspects of culture.”²⁰ Many of the current social and health problems experienced by Native American and Alaska Native communities have been attributed to historical trauma. Re-traumatization can have a profound effect on health, and intergenerational trauma may negatively impact subsequent generations if historical trauma is not processed therapeutically.²¹

Dr. Brave Heart talks about the process of moving forward from historical grief to prevent the destruction of cultural identity and how that might impact subsequent generations. “First is confronting the historical trauma. Second is understanding the trauma. Third is releasing the pain of historical trauma. Fourth is transcending the trauma.”²⁰

Researchers of adverse childhood experiences (ACEs) are recognizing that an understanding of violence and trauma exposure needs to include concepts of historical trauma. Historical trauma can contribute to how we view the cumulative burden of trauma and the interconnection among forms of violence and abuse. Hamby and colleagues note the need for “the integration of historical trauma into the poly-victimization framework for Native communities in order to more accurately capture the true burden of victimization.”²²

Indian Boarding Schools

One example of historical trauma are the boarding schools enforced on Native communities by the federal government. Established in 1879, these residential schools are estimated to have peaked in number by 1887.²³ The US government made it a federal policy that all Native American children were to attend such schools. The history of the boarding schools was one of an all-out attempt to “kill the Indian to save the child.” As clearly stated by Colonel Richard Pratt, founder of the first off-reservation Native American boarding schools, “all the Indian there is in the race should be dead.”²⁴

Although we know that often the environment also killed the child physically through communicable diseases, and mentally through identity-crushing tactics; it broke the traditional educational systems of tribal communities, disparaged their families and communities, their languages, rituals, values, and their identities.²⁴

Olson and Dombrowski proposed numerous social-psychological implications as a result of separating children from parents by the “naiveté of school officials:” familial and parental attachments were damaged; important cultural dynamics that define identity and sense of well-being were never fostered; and cultural practices, ceremonies, and coping strategies, important for dealing with the current trauma of the boarding school experience, were never developed in the children. Thus, “Native American children suffered a dual loss — identity and family connection.”²⁵



An emerging research area with respect to historical trauma is based on the theory that a collective trauma experienced by one generation can negatively impact the wellbeing of future generations. The biological pathways through which historical trauma can affect the well-being of a future generation is unclear. Kealohi and Thayer³³ propose two models for the possible connection between historical experiences and the health of future generations. Both models include the concept of epigenetics, which is the study of changes in heritable traits that do not involve alterations in the expression of DNA sequences but rather gene expression. Such expression may be the result of environmental influences or experiences. The first model suggests that personal exposure to trauma or stressors, which are more common among populations that have experienced historical trauma, can induce epigenetic modifications that can contribute to the development of poor health.

The second pathway posits that poor health can occur through intergenerational epigenetic modifications in response to parental and grandparental trauma or stressor exposures. The authors conclude that because epigenetic modifications are possible, trauma-induced epigenetic effects are not necessarily permanent. Favorable environmental conditions may reduce the high prevalence of poor health among historically disadvantaged communities.



A detailed study of researchers with secondary trauma was conducted by Williamson and colleagues.⁷ The impacts on researchers working with information about traumatic events or with traumatized individuals has not received much attention in the literature.³¹ This research study involved the administration of a detailed interview to a large group of researchers who had completed a study of gender-based violence. Based on a qualitative analysis, the authors concluded that, whereas researching this subject can lead to secondary trauma and other negative impacts, many coped through support from colleagues, used personal resiliency, and felt comfort that doing the research helped the victim by giving them a voice. Barriers included working remotely and thus not being able to connect to other researchers, employing unhealthy coping strategies, and feeling frustrated that nothing had changed for the victims of this kind of violence.

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Secondary Trauma During COVID-19

The COVID-19 pandemic is unprecedented and brings on several challenges for society and especially for tribal communities. In many cases, resources will be stretched to the limit by an infectious disease outbreak as we have already seen with COVID-19. Other unique challenges tribes may face include drastic change in the way they operate as a community, and the best practices for reducing the spread of the disease has greatly impacted the traditional cultural practices shared among tribal members. Engagement and communication among community members becomes complicated with increased infection control measures such as social distancing and the use of personal protective equipment (PPE); family and friends may not be able to visit and perform ceremonies as a community. Tribes have remained resilient with ceremonies in difficult times such as illness, loss, and grief; as well as those for rites of passage, and the inability to perform such ceremonies due to social distancing measures may heighten anxiety and stress, and this fear of contagion may trigger memories of past traumatic events.

Addressing Secondary Trauma

Experts view the coping strategies, social supports, and resiliency traits that are effective in the prevention of or treatment for secondary trauma and secondary trauma stress (STS) as similar.²⁶ The literature highlights several approaches and strategies to address secondary trauma/STS:^{27,26}

1. Strive to increase job satisfaction
2. Effectively detach from work when not at work
3. Surround oneself with caring supports
4. Have a strong sense of purpose of one's work with trauma victims
5. Educate oneself on the signs of secondary trauma
6. (Organization-level) Screen prospective employees for stress resilience
7. (Organization-level) Implement worksite incentives for health-promotion behaviors



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Future Directions

The emotional cost of caring by trauma workers can be considerable.² Designing programs that enable trauma workers to avoid secondary trauma while assisting and providing support to trauma victims is a high priority in this field. Specific research questions that merit attention in order to inform the development of such programs include the following:

1. Defining and measuring what constitutes trauma
2. The effects of personal traits and organizational culture on the onset and course of secondary trauma
3. The role of preparatory and ongoing training for people in professions who in some form will be or have been exposed to trauma victims
4. Tailoring intervention programs based on the type of profession
5. Developing individual and organizational-level programs.^{28,16,29}

Given the variability of whether secondary trauma develops or not among people who work with trauma victims, a better understanding of what factors are predictive of those at risk for developing secondary trauma or STS can form the basis of these programs.²⁶

The role of enculturation is paramount for the health and well-being of Native American and Alaska Native people. The integration of Native cultural and spiritual practices are also a key to providing effective avenues to address secondary trauma and related stress.

A 14-year study of adverse childhood experiences (ACEs) of a large sample (17,337) of adults who received health care from Kaiser Permanente, a health care maintenance organization in San Diego, examined the link between ACEs and subsequent health problems.³² ACEs included 10 types of child trauma, 3 types of abuse (sexual, physical, and emotional), 2 types of neglect (physical and emotional), and 5 types of family dysfunction (having a mother who was treated violently; a household member who is an alcoholic or drug user, who is been imprisoned, or diagnosed with mental illness; or parents who are separated or divorced). More than half of respondents reported at least one, and one-fourth reported 2 types of an ACE. Researchers found a statistically significant relationship between the number of ACEs of childhood exposure and each of the adult health risk behaviors and diseases that were studied. Persons who had experienced four or more ACEs, compared to those who had experienced none, had multiple-fold increased health risks for these health problems as adults: substance use disorder, depression, smoking, severe obesity, and poor self-rated health. Also, a similar pattern was found for these adult diseases: heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The data also showed that persons with multiple ACEs were likely to have multiple health and disease problems later in life.

Suggested Readings

Culture is Prevention Project

This multi-phased community-based participatory research project was initiated by six urban Native American and Alaska Native health organizations in northern California, and aims to promote strength, health, healing, and wellness improvement with culturally informed or Indigenous methods.

King, Janet; Masotti, Paul; Dennem, John; Hadani, Shir; Linton, Janice; Lockhart, Bonnie; and Bartgis, Jami. (2019). The Culture is Prevention Project: Adapting the Cultural Connectedness Scale for Multi-Tribal Communities. *American Indian and Alaska Native Mental Health Research*. 26:3. Retrieved from https://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume-26/26_3_2019_104_king.pdf.

Resilience for Trauma-Informed Professionals

Resilience for Trauma-Informed Professionals is a curriculum for providers which focuses on six core elements - appraisals, self-efficacy, emotional awareness, affect regulation, resilience, and prevention - for navigating the experience of working with trauma victims.

Kerig, Patricia K. (2019). Enhancing Resilience Among Providers of Trauma-Informed Care: A Curriculum for Protection Against Secondary Traumatic Stress Among Non-Mental Health Professionals. *Journal of Aggression, Maltreatment & Trauma*. 28:5, 613-630, DOI: 10.1080/10926771.2018.1468373. Retrieved from <https://www.tandfonline.com/doi/abs/10.1080/10926771.2018.1468373>.

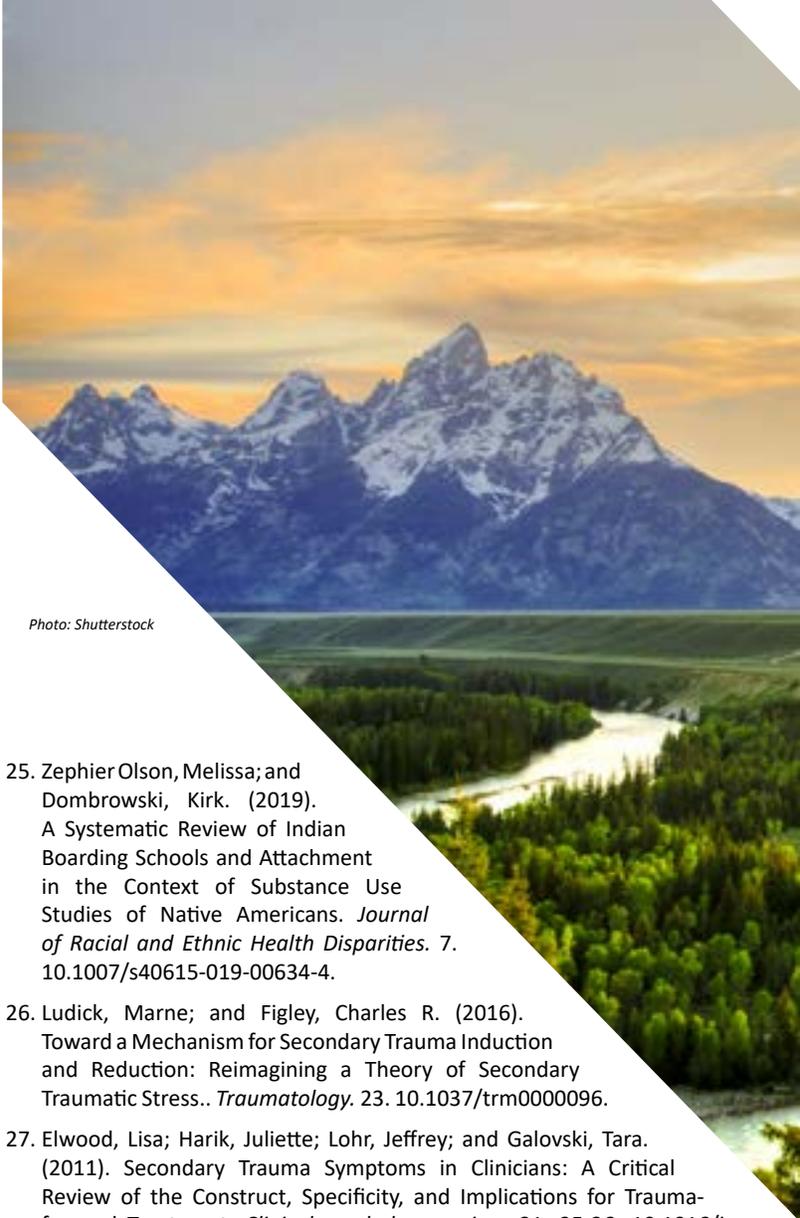
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As we have entered into a time we have known was coming, we can only look and step forward into what the Creator has planned for us. Let us not forget that we do not control the future, nor the environment, but are a part of it. Remember what you have come here for, as that is part of our first step towards finding ourselves and our roles during this time that has already been determined.

Sean Bear

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- Photo: Shutterstock
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Resilience in the Face of Trauma

A conversation with Dolores
Subia Bigfoot, PhD

*Professor and Director of the Native
American Programs at the Center
on Child Abuse and Neglect at
University of Oklahoma Health
Sciences Center*



Dr. Dolores Subia BigFoot is a member of the Caddo Nation, is trained as a child psychologist and is an Professor and Director of the Native American Programs at the Center on Child Abuse and Neglect at University of Oklahoma Health Sciences Center (OUHSC). Funded since 1994 by the Children’s Bureau, she has directed Project Making Medicine and since 2003 she has directed the Indian Country Child Trauma Center where she has been instrumental in creating culturally adapted interventions of evidence-based treatments (EBT). Dr. Bigfoot was also the 2017 recipient of the Dr. Duane Mackey Waktaya Naji Award.

Under her guidance, four EBTs were adapted for Native American and Alaska Native (NA/AN) families in Indian Country titled the Honoring Children Series. One of the four is Honoring Children, Making Relatives, a cultural adaptation of Parent-Child Interaction Therapy, for use with Native children and their families. It incorporates NA/AN teachings, practices, rituals, traditions, and cultural orientation while maintaining the guiding principles and theory of Parent-Child Interaction Therapy. She is a past president of the Society of Indian Psychologists, has over 40 years of experience, and is knowledgeable about the concerns of implementation and adaptation of evidence-based practices being introduced into Indian Country. (source: Indian Country Child Trauma Center)

Cindy Sagoe: Tell us about yourself, and how you got into this field of work.

Dr. Dolores BigFoot: I’ve been doing this for 40+ years, and the motivation for the work that I do began when I was a young mother with newborn babies. I found myself in a situation where I needed to ask for help. However, the help that was offered was: in order for me to get back to work to take care of my family of three children, I was to give my children up? That didn’t seem helpful, as the reason I was going to work was for my children and having some resources. That was my motivation for finding services for families who are in need without breaking them up. My motivation has always been to find ways to support families, especially American Indian families, and most especially American Indian children; so that they feel safe, are able to thrive and manage life’s challenges, and also that they would know who they are, where they came from, and why they are here.

I have worked with foster care, behavioral health, substance abuse, Head Start, and child development. It’s been about building blocks. I started working in Head Start over 30 years ago, which is pretty amazing.

CS: Indeed, that is amazing. In your experience, what is secondary trauma and what increases the risk of secondary trauma?

DB: There are different terms for secondary trauma: vicarious trauma, compassion fatigue, etc., so really, trauma is...trauma. With secondary trauma you think in terms of degrees of removal from the threat.

Sometimes trauma threatens us directly. How far you're removed and how much exposure you get to those with direct exposure determines your potential risk. Even now with COVID-19, it's heartbreaking for those who work in circumstances that are putting them in danger, while serving those suffering from this pandemic. Such individuals are at risk of experiencing secondary trauma.

Our experiences have different impacts on our responses. Looking back at the Oklahoma City bombing in 1995; the way that direct threat impacted our families and the way we do services now is similar to threats like tornadoes. You think about how much of those reminders trigger us; those pictures and intrusive thoughts of danger, even if we are not in direct danger of it, our mental capacity to respond to that. Most of the time when we are working with children or clinicians who are working with families, their children and others have had trauma. Trauma is broad; so child sexual abuse, or a car wreck, tornado, bombing, human trafficking, is all under that broad explanation and for an individual person there could be multiple or single traumas.

Almost everyone has dealt with threats to their lives, like a car accident, and getting back into that same or similar situation can also be traumatic. Trauma must be appreciated in the full sense of how it impacts a person's ability to manage what feels threatening to them.

CS: Looking at the current times with COVID-19, I personally have not had direct contact. However, listening to the news, and even talking with a family and friends who may have been exposed has made me anxious and fearful; and I haven't thought about it that way, that I may have been exposed indirectly to the trauma by listening to the stories of those having a direct experience.

DB: Exactly, it's a sense of not being able to make decisions, not having control of the situation, or not knowing what to do. That sense of loss of control and lack of reliable information or not being able to see loved ones to offer support. How do we manage disappointments or uncertainty that create anxiety and stress? This is where the traumatic reaction comes into play.



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CS: As you mentioned, children, clinicians, and those in everyday life could be exposed to secondary trauma depending on the environments around them. In these COVID-19 times, how can we see the signs, and what are ways others can fight, manage, or possibly prevent exposure to secondary trauma?

DB: Understanding secondary trauma and how it affects others is important. If you are a firefighter, an ER doctor, schoolteacher, funeral home director, or bus driver, not understanding how and who you are going to have contact with, as well as how to protect your family members can be stressful. We hear on the news how family members are worried about their partners who are frontline healthcare professionals. Because relatives are aware of the dangers their family on the frontline face, it creates anxiety. So, when someone says and shows that they are taking precautions and trying to do everything to protect themselves with masks, clothing, and a decontaminated area in their house and other process to be safe, this decreases that anxiety for relatives.

It's understanding how your experiences are impacting you. Some people can get anxiety and wonder why they can't sleep, why their stomach feels weird, why they are short with other people, hypervigilant, etc. If they don't understand that this is an effect of coping with an unseen threat, it might affect how they feel. Knowing how far removed the threat is, and if they are fearful for themselves vs. fearful for someone else is important to acknowledge. It is the same behavioral and mental characteristics of trauma that are true for vicarious trauma, too.

The National Traumatic Stress Network has great materials about vicarious trauma (shared below). The Office of Victims of Crimes has developed a vicarious trauma toolkit for victims of crime and it is helpful to understand how that impacts the wider circle.

There's the trauma that is the individual's experiences and that of those closest to them, and how that moves away. The effects are similar, there is stress, anxiety, worry, hypervigilance, and some people may avoid talking about things.

It's human nature to cope the way that we do, but it's also about how best to address those problematic coping mechanisms. For example, I was heavily impacted by the Oklahoma City bombing where I spent time working. Now I acknowledge it each year, but I don't necessarily visit so as to avoid triggers. I recognize that, and I avoid it. While it's a great place to visit to learn more, I don't have the need to go there. That is the recognition we need when we are engaged in behaviors that disrupt our lives, making it difficult to manage our lives in a productive and thriving way. Many individuals may have difficulties with intrusive thoughts and focusing, causing them to lose contact with their family, have trouble sleeping, start drinking, doing things they ordinarily wouldn't do.

Humans have always encountered things that threaten their lives; for example, tornadoes occur here (Oklahoma City) every year; earthquakes, flooding, etc. Those things are not just current natural events, they have been happening for generations and have always impacted the quality of life in the area, just like other natural disasters in other parts of the world, so learning to deal with that is helpful and reduces anxiety.

In our tribal communities, we have managed with ceremony which was used to prepare for something that was going to be difficult like preparing for war, having, or losing a child. Ceremony was used to make it through difficult times and then afterwards to express gratitude. When you take away something that was a part of the society like ceremony, in many levels and degrees people lose their way of coping that allows them to thrive, feel whole, and balanced. Now bringing back different kinds of ceremony, such as offering of tobacco, etc., brings down that anxiety and stress and uncomfortable feelings.

Understanding what trauma is and what is helpful to address that level of threat, and to bring back that level of safety as one or many in ceremony, and to have consistency all help to reduce the stress and anxiety that comes with being exposed to trauma. Tribal communities have been trauma informed forever, and it's a term that we are just now using as it is being exposed as trauma exposure and secondary exposure.

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"My motivation has always been to find ways to support families, especially American Indian families, and most especially American Indian children; so that they feel safe, are able to thrive and manage life's challenges, and also that they would know who they are, where they came from, and why they are here."



“It’s human nature to cope the way that we do, but it’s also about how best to address those problematic coping mechanisms.”



Photo: Ruslana Iurchenko/Shutterstock

CS: What are programs or projects that you know have had an impact?

DB: There are a lot of different programs. Programs that we offer include several clinician trainings for treating child clinic trauma (Honoring Children, Mending the Circle). We also do Parent Child Interaction Therapy for behavioral problems and for parents who have issues being consistent parents. We know that adverse childhood experiences have a very negative effect if they are present in a child’s life without consistent parents or adequate support around them.

We also offer programs for the treatment of problematic sexual behavior, providing clinical treatment for adolescents with illegal sexual behavior, as 40% of child sexual abuse is from adolescents who molest or sexually assault younger or same age peers.

Looking at what is available for firefighters, police, medical professions, teachers - the core of effective treatment is targeting. All these careers have unique aspects and skills in them. Police officers put their lives on the line, especially with domestic cases. They have skills in de-escalating situations, thus being able to decrease the threat in a domestic violence situation. School teachers also need specific skills for students being on schedules and coordinating large groups. There are a lot of resources out there that many disciplines can draw on.

There are many resources, but implementation and utilizing them in a way that is the most helpful for those specific situations is important. With Honoring the Children, if the clinician is unable to see the child on a consistent basis, it won’t be helpful. We have the resources, but it’s the treatment barriers and implementation that are our biggest obstacles.

CS: What are your recommendations for building resilience in ourselves, providers, clients, and communities in the face of trauma?

DB: Resiliency is really about the ability to not feel overwhelmed over the long haul. Individuals can certainly feel overwhelmed in the moment. It’s like we are driving along and somebody runs a red light and we have to do some defensive driving maneuver and end up hitting the side of the curb or something like that, and our heart is racing. In that moment, it is hard to figure out if we want to get sad, scared, or mad - all kinds of emotions are going through us. We probably tore up the car, and we think “thank goodness no one else is in the car with me.” It’s all kinds of emotions. So, it’s in our ability to calm down, jump out of the car, and make sure that other people are safe. This reaction is going to ebb and flow until it kind of disappears and becomes a memory to where it’s not a harsh reaction anymore.

“When you think about resiliency, it’s the ebb and flow of our ability to manage our anxiety, stress, and thinking, and to be resourceful in times of crisis.”

Resiliency is recognizing triggers and the things that are going to impact you, and it’s recognizing that “yeah, that was a really bad time. You know, I got so scared, but I got through it.”

Resiliency is being able to self-talk about what it is that is manageable and to prepare for the future in some way “When I go to that street again, I am going to make sure I’m going slow enough and I’m going to watch out for cars.” If you tell yourself, “I can’t go down that street anymore, every time I get in the car I get anxious, I check my seat belt over and over again.” That will make it difficult to manage, and hinders resilience and our ability to cope.

When you think about resiliency, it’s the ebb and flow of our ability to manage our anxiety, stress, and thinking, and to be resourceful in times of crisis. It’s also the ability to have resources and understand how they can help.

CS: Thank you Dr. Big Foot, I learned so much. It also made me think introspectively. I really appreciate it and I am grateful for your time.

Resources Mentioned

[The Vicarious Trauma Toolkit](#)

[National Child Traumatic Stress Network](#)



*Photo: Ruben M. Ramos/
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RECENT & UPCOMING EVENTS



Date	Event	Participation
Bi-weekly on Fridays	Connecting Prevention Specialists to Native Communities During Times of Crisis: Listening Sessions - this has been a weekly meeting and will be continuing bi-weekly on July 10	Register
April 29	Building Resilience in Our Patients, Communities, and Ourselves in a Time of COVID-19: Lessons for Behavioral Health Providers	View the recording
May 20	Historical Trauma: Definition, Impact, and Hope for Healing	View the recording
May 20	Trauma, Adverse Childhood Experiences, and Their Impacts on the Health and Wellbeing of Native American & Alaska Native People	View the recording
June 4 and 11	Motivational Interviewing During Challenging Times: Re-examining the Concept of Ambivalence and Working with Change Talk	View the recording
June 10	Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training	View the recording
June 17	Wellness for Providers session 1: Self Care in Times of Crisis	View the recording
June 24	Wellness for Providers session 2: Coping with Grief	View the recording
June 29 - July 1	Let's Connect (LC): Training for Family Providers	Online
July 8	Culture is Prevention Session 1: Different Cultures, One Vision	Register
July 14	Culture is Prevention Session 2: The Resilience of Spirituality in the Native American Culture and its Role in Prevention and Healing	Register
July 15	Wellness for Providers session 3: Managing Stress	Register
July 22	Wellness for Providers session 4: Resilience and Summary/Review of all sessions	Register
July 22	Culture is Prevention Session 3: Spirituality in the Hispanic and Latino Culture And Its Role In Prevention And Healing	Register
August 4	Culture is Prevention Session 4: How We Can Culturally Navigate Between The Two Communities	Register

Only when it's too late

We tried to guide them,
Yet they considered us lost.

We tried to show them,
Yet they looked away.

We tried to tell them,
Yet they wouldn't listen.

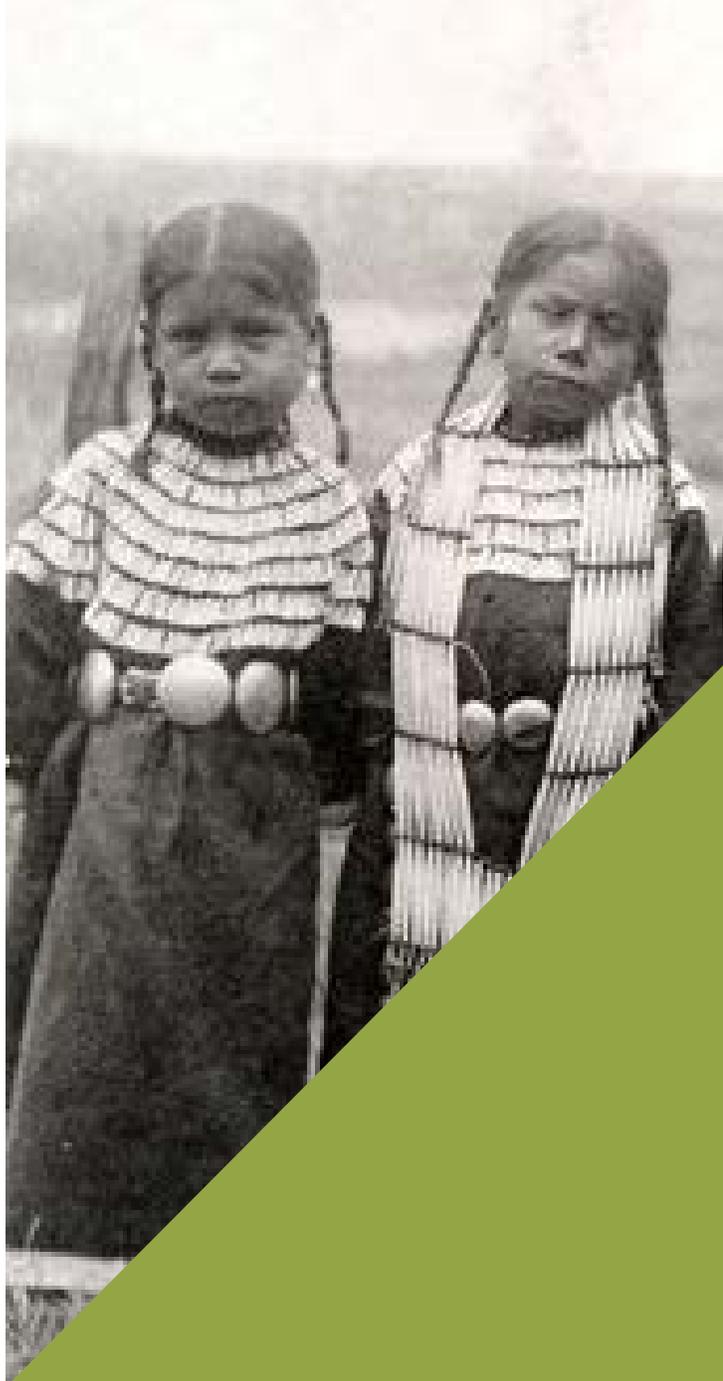
Only when the dust has filled the tracks will they try to follow.

Only when we cannot be found will they want to be shown.

Only when we cannot be heard will they want to listen.

Only when it's too late.

Sean Bear



National American Indian & Alaska Native

PTTC

Prevention Technology Transfer Center Network
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