

**Staying Inside Our “Window of Tolerance”:
Strategies for Managing Secondary Trauma and Distress**

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KATHLEEN MURPHY: Hi, everyone. Again, welcome to our webcast, staying inside our window of tolerance-- Strategies for Managing Secondary Trauma and Distress. This webcast is brought to you by the Center on Knowledge Translation for Disability and Rehabilitation Research, which is housed at the American Institutes for Research. We're funded by the National Institute on Disability, Independent Living, and Rehabilitation Research, known to those in the know as NIDILRR. NIDILRR is housed by the US Department of Health and Human Services in the Administration for Community Living.

My name is Kathleen Murphy, as Shoshana mentioned. I direct the center on KTDRR, and I'll be your moderator for today. I am a middle-aged white woman with shoulder length blonde hair. And today I'm wearing a light blue blouse under a gray sweater.

So today we'll hear first from Dr. Ginny Sprang. She is a professor in the College of Medicine, the Department of Psychiatry at the University of Kentucky and also the executive director of the UK Center on Trauma in Children. So her presentation uses the latest research on secondary traumatic stress, burnout, and compassion satisfaction to provide evidence-informed strategies to understand and respond to workplace stressors.

And we asked her to take a particular focus in her presentation on the secondary trauma that teams may experience as they engage in research with communities that have experienced trauma. And we picked this topic because it came up in a workshop we had with some of the NIDILRR grantees in the spring, that they were finding that some of their researchers, their interviewers, focus group people were experiencing this reaction and not knowing how to handle it when they were talking to some of-- in this case, it was a project where people were experiencing economic distress, the research participants.

So anyway, after Dr. Sprang finishes, we have Dr. Allison Taylor here. And she's going to provide some reflections, particularly making that tie back to how the presentation might apply to disability researchers. Dr. Taylor is a senior research associate at the Institute for Community Inclusion at the University of Massachusetts, Boston. And she already has done research on this. She was awarded a 2020 NIDILRR Switzer Fellowship to study trauma-informed approaches at centers for independent living, which are centers that are run by and support the needs of people with disabilities in the United States.

So that's really all my intro. I think we can turn now to you, Dr. Sprang.

GINNY SPRANG: Thank you, Kathleen. All right. Well, welcome to our webinar. As Kathleen mentioned, I'm Dr. Ginny Sprang with the University of Kentucky. I'm also a middle-aged white woman with light brown hair. And I have a long-sleeved black shirt on today.

And in addition to the introduction that Kathleen shared with you, I wanted to just tell you a little bit about myself and how I came to be interested in this topic of secondary traumatic stress and occupational stressors. So my very first paid position in graduate school was to provide therapeutic services to family members who had lost a loved one due to murder.

This is all I did 40 hours a week. And at that time, there wasn't much talk in my graduate training program about secondary traumatic stress. In fact, that term wasn't even being used. Compassion fatigue was still not even something that was in the literature yet. And certainly, I had some experiences, having lots of exposure to indirect trauma material in the work that I was doing with family members of murder victims.

So at the conclusion of my PhD program, when I went into academia and launched my research agenda, I found myself in many situations as a researcher where I was, for example, doing a study of child fatalities, precursors to child fatalities, and near fatalities. Another study I did, I was having to code the severity of child maltreatment by reading detailed records about child abuse histories.

And I found that I had a lot of exposure to some really graphic details. And certainly I felt the weight of those exposures and had a response to those that I now know would kind of fall into this category of secondary traumatic stress. As my career has developed, I'm now the center director for our translational research center that does only trauma work and trauma research. And certainly, I see the effects on my staff, my faculty, and in the work that I'm doing as a translational researcher.

And then finally, just as a policymaker and someone who has run groups that I've been the president of the STS consortium, the chair of the STS collaborative group for the National Child Traumatic Stress Network, and have worked on policy issues. So I'm just sharing this with you because I feel like I understand secondary traumatic stress with my head and my heart.

I've lived it in many different ways. I've felt it. I've tried to help other people with it. And I've certainly been an observer, an objective observer through the research process of the phenomenon. So all of those are the things, the experiences that I bring and the context for this presentation.

So our learning objectives-- what I want to do in the short time that we have together is to try to give you some skills to help you self monitor and make sure that you stay inside the window of tolerance whenever you are faced with an occupational stressor. And some of that will involve how we can use peer and supervisory support strategies to address secondary traumatic stress and build up our resilience.

And we're going to take a in-the-moment perspective. So my goal is to teach you some things that you could do in the moment when you begin to feel dysregulated instead of this approach where you wait till

you go home, you feel battered and maybe a little distressed because of what's been going on, and you try to repair yourself later. We're really wanting to think about real-time practice strategies.

So we're going to start off with just some definitions, not to belabor the point but to make sure that people understand some of the differences between some of the different things we're going to be talking about. Burnout-- everybody has heard the word burnout. You know about this. Burnout is from working long hours in under-resourced environments, where you don't have a lot of flexibility. It's hallmarked by cynicism, emotional exhaustion, low job satisfaction.

People that are burned out can work anywhere. They can work in a widget factory. They could work on the line in a manufacturing company. There doesn't have to be any kind of trauma exposure. So burnout is something that affects most workers in some way, but it is in no way a trauma condition or related to traumatic stress.

Other people might also experience something called moral distress. And this is when we know what the right thing to do is because of our values, our ethics, our policies, and our protocols. But for some reason, we're not able to do the right thing. So for example, if you're doing disability research and you feel like someone needs a particular resource to improve their well-being, but because of financial constraints, lack of insurance, or some type of policy, they can't access what they need. And so you may feel a lot of frustration or distress about the system or the bureaucracy that prevents barriers and hurts the people that you're interacting with. And this has certainly been an issue during COVID, where people have been concerned about supply shortages, resource shortages, and the inability to access the care they might need in the COVID environment.

And then there's secondary traumatic stress. And we're going to spend some time parked out here talking about this concept of secondary traumatic stress. And this is really a condition that parallels post-traumatic stress and post-traumatic stress disorder. But it's not reducible always to PTSD. So it's when we are exposed indirectly to the trauma experiences of other people. So if you're a researcher and you're doing qualitative research, for example, you may be interviewing people about their experience, and they're sharing some graphic details of their trauma experience.

And we know from the literature and also the current DSM-5 depiction of what post-traumatic stress is, that we can be affected, and we can develop post-traumatic stress symptoms from these types of indirect exposures of other people. So when I think about secondary traumatic stress, I think about all the research that is out there and research that I'm currently doing. And so this particular slide shows you the continuum of traumatic stress responses that can occur after an indirect trauma exposure.

So a recent study that I did, where we did clinical interviews using the STS clinical algorithm that I developed and the CAPS, the clinician-administered PTSD interview, we found that there are basically four categories of responses to indirect trauma exposure. So there are people that might have an exposure, and they really don't have any type of response. So they don't develop any trauma symptoms.

They may feel a little distress. They may say, man, I need to go take a walk. But they're not experiencing any symptoms of post-traumatic stress that lasts beyond just maybe the first few minutes. That's about

15% of the sample that we interviewed. These are professionals that were providing trauma services to children.

The second category are those individuals who may have some trauma symptoms due to indirect exposure, but there's no functional impairment. They're still going to school. They're going to work. They're interacting with their family. So it's distressing to them, but it's not changing the way they function or operate in the world. That's about 23% of the sample that we recently examined.

The next group are those who have trauma symptoms, and they have some functional impairment. This can be mild to severe, but they don't meet criteria for PTSD. And in my research, this is generally because they spike on symptoms of intrusion and arousal, but they have very low avoidance. That's the largest group, right around 30%.

And then the final group are those people who develop PTSD due to an indirect exposure. Under 25% of the sample usually falls into this category. And these are folks that just have both the functional impairment and they meet all the criteria for PTSD. And so when we talk about those criteria, we're really talking about symptoms in these four categories-- intrusion, so these are flashbacks, nightmares, having physiological reactions or psychological distress due to thoughts about the content that you might have gotten when you did that interview or you talk to that survivor in a research study. Avoidance-- both internal and external reminders, alterations of cognitions and mood-- so we see a sense of-- for a shortened future, more negative emotions, inability to feel positive emotions, expecting something bad to happen.

And then this category of alterations and arousal and reactivity-- so this is hypervigilance and irritability and exaggerated startle response. And so these are the kinds of symptoms that we see people having due to this indirect exposure. And so this can be hearing the story, reading about the story in records, like I told you when I was doing that fatality study digging through these investigative reports. It could be having to testify about what you've seen or heard or someone's told you, about having to recount that to other people over and over. These are all ways that we see people being exposed.

So I'm going to share a video with you. This is a real short-- it's just like a five-minute video. And then we're going to talk a little bit about it. But this is just a perspective, someone sharing their experience. And so you can kind of see how it manifested for this person. And this, the person talking, is a friend of mine. It's Laura van Dernoot Lipsky. She runs an organization called Trauma Stewardship. And she did a Ted Talk about it, which I think was really interesting and insightful.

So I'm just going to make sure that I'm sharing my sound. Yeah. And I'm going to see if Shoshana could just let me know if the video is playing correctly.

[VIDEO PLAYBACK]

- Now that all of you have so much more insight and personal awareness than I did back in the day and that for those of you who know what this toll is and when you feel this toll, either because of what's going on in your personal lives or on the job, that you're able to identify it. But I was not at all able to identify it.

So it was about 10 years into my career when a critical mass of people started kind of getting up in my face doing that, "Hey, Laura, you're tripping. You should take some time off."

And I'm sure somebody said something earlier than 10 years in, but I was very stubborn and successfully ignored them. But 10 years in is when there was a critical mass of people up in my grill really begging me to look at this. And what some of you will appreciate is that a number of those people were clients I was serving, which you can imagine is always so disconcerting-- survivors of domestic violence living in a shelter who can't go anywhere begging me not to come to work. So people were doing their due diligence, right?

But at the time I was so arrogant, I was incredibly cocky, and I was entirely self-righteous. I was doing God's work. You could either step up and help me do God's work, or you could step off. But I was definitely not going to have a conversation with you about how I was affected by my job.

And like many of you possibly, I was raised in a number of traditions that implicitly and explicitly communicated, "if you care enough about what you're doing, if you are down with your cause enough, if it matters enough to you, you're going to suck it up." So this whole conversation about how to sustain was not something I was engaging in.

But finally the pressure mounted. I caved. I didn't take any significant time off, but compromise, we took a short trip, went to visit our family who lived in the Caribbean. So on a particular day, we head out as a family on this hike. And we get halfway through our hike, and we summit what we wanted to summit. And there we are standing on the top of these cliffs, right?

So the family is gathered around, tiny Caribbean island, standing on the top of these cliffs looking out. The first thing I remember thinking was, "this is so beautiful." The second thing I immediately thought was, "I wonder how many people have killed themselves by jumping off of these cliffs." And at the time, I worked at Harbor View Hospital, which you know is the level-one trauma center for the whole Northwest. So it wasn't my own suicidality at play anymore. It was because of the years of bearing witness to other suffering that naturally, instinctually one starts triaging. Of course, right?

So you start thinking, where would the helicopter land? Does the helicopter land on the cliff, and would you belay down to the person on the beach? Would the helicopter actually land on the beach? Is there a level-one trauma center in the Caribbean, you ask yourself. Do they fly you to Miami? Would they stop you in customs? You know, you kind of go through the whole thing.

So I said this out loud because I was merely presuming I was just giving voice to inevitably what was going to come up in a family conversation. Because who stands on top of a cliff and does not wonder where the nearest level-one trauma center is? But apparently in my family nobody was thinking that.

So it got even quieter than it had been, really long, very uncomfortable pause happened. And ultimately it was my stepfather-in-law who said, "are you sure all this trauma work hasn't gotten to you?" And honestly, this was the first moment I had any insight into check it out. There are people who can go on a

hike and not wonder where the nearest level-one trauma center is. But I'll tell you, it wasn't me. It wasn't anybody I was hanging out with. Because one of the things about this toll is it's slow moving.

It is very hard to gauge over time, individually and collectively, if we are being affected by what we're exposed to. And also what happens is we get very isolated. So this was one of those moments that maybe you've had where everything starts flooding in. And then I was like, whoa, well if this is the case, maybe it's also the case that there's people who still date out there in the world. And those people who date aren't doing background checks on everybody they date, right?

Maybe there's people who can go to a playground and it's just a lovely place for children. You're not worried about head injuries or AMBER Alerts, right? But this is what happens, that over time what you're exposed to affects your entire worldview.

There are so many ways that we can be affected individually and collectively by exposure to vicarious trauma, compassion fatigue, secondary trauma. Many people call it many different things. But this exposure affects all of us so differently. What I have found, through the privilege of getting to work with everyone from zookeepers to judges, school teachers to nurses, ecologists to activists, is that it is breathtaking the commonalities of how one is affected.

So some of the ways we find, you feel like you're not doing enough. So here they're saying, "we just haven't been flapping them hard enough." So this is where you feel like you're not doing enough, you constantly feel like you should be doing more. Another one could be morale. So they're saying, "I see you've done time. So working in a cubicle shouldn't be a problem."

So I work with organizations, nationally, internationally, and one of the things we find so much is the morale, the very, very quickly eroding morale. Here he's saying, "I bark at everything. You can't go wrong that way." So hypervigilance-- many people can relate to a sense of hypervigilance. This is where you lose your ability to flow in really fluidly in between your sympathetic and your parasympathetic nervous system. You become in kind of in hyperarousal.

I had a colleague say to me-- she was a child support enforcement officer-- and she said to me, "I can tell you which ones of my son's friends are going to grow up to not pay their child support." [LAUGHTER] and her son was five years old, right? Here he's saying, "No, not there, please. That's where I'm going to put my head." So exhaustion is something many people can relate to, and not the exhaustion before you work out. But this is an exhaustion where you are tired in your soul, you are tired in your spirit, you are tired throughout your bone marrow. All of your ancestors were tired people.

There is the avoidance. He's saying, "no, Thursday's out. How about never? Is never good for you?" This is where the best part of your day at work is where you don't have to do your job. And then there's the avoidance in our personal lives. She's saying, "It's too late, Roger. They've seen us."

[END PLAYBACK]

GINNY SPRANG: All right. So I think Laura did a really good job of describing what it might be like to be in a job where you have exposures. And that these exposures kind of unfold over time. So there's a couple of little things I want to pull out of this video that I think are important. The first is that she makes the point that the changes that you might experience unfold slowly over time. They creep up on you.

It's not like you wake up one morning and you feel different. It's a lot of mornings of subtle changes in the way you view the world, the way you view your job, the way you view your own self-efficacy. And the other point I want to make is, even though she was giving a pretty general statement about occupational distress, she also pointed out some trauma symptoms in her description.

So I was just going to open it up to you. And just take a minute and have you put in the chat what trauma symptoms you heard Laura talk about as she talked about her experience. All right, so I see avoidance--absolutely-- not only avoiding other people and kind of shutting down, but kind of avoiding some of her own internal states that maybe were telling her something was off. Catastrophizing and hypervigilance--yes, absolutely.

Anxiety. Yeah, there was also some social withdrawal, kind of an overall lack of personal awareness and just a lot of psychological fatigue. That's right, Susan, an inability to recognize what was happening, disengagement, extreme exhaustion. Yes, she made the point that she was so tired, she was tired down to her bones. And that's certainly a type of fatigue I've heard other people describe when they talk about how they feel when they're exposed to these stories day after day.

All right. So there are reasons why some people fall in that first category I told you about of people who don't have many symptoms of distress when they're exposed and those folks who might end up in the most extreme PTSD category. So let's talk a little bit about the complexity of the STS context.

The first thing that I want to talk about is the nature of exposure. When we really dig deep into why did some of the individuals report absolutely no reaction to indirect exposure, when we looked at their clinical interviews, we did see differences in the types of exposure, the severity of the trauma content, and the full dose, so how often it was happening over time. So generally we know from the research that, if you're in a field where you are getting a lot of sensory material, so people are either describing to you the sounds, the smells, giving you vivid graphic detail that you have to then process, that you are more likely to have a larger dose of exposure.

Some people might only have these exposures once or twice in their career. Other people are having them multiple times a day. So we know the nature of the exposure can differ and that that's important. There's also our own personal risk profile. Some of us come into the work and we've had our own exposures to other traumatic events, either as children or adults. Those things may be in the past and resolved. They may be in the past and unresolved. Or they may be ongoing.

And we don't really know what our coworkers are dealing with. And so we always want to be aware that whatever work we are doing, it has the potential to trigger us by presenting trauma reminders that may activate our own unresolved issues or at least bring up memories, distressing memories. And there are other risk factors that are associated with PTSD. If we have other mental health conditions, if we had a

parent, for example, that had mental health or PTSD issues and we learned about coping with distress from them, that could be a risk factor.

We see women reporting higher levels of PTSD, probably not about gender, but more about the types of events that women are exposed to, namely sexual violence, because that is a signature risk. It carries more salient and disproportionately deleterious impacts on people.

There are also these environmental contexts that differ between different professionals. Some people are operating in communities where there have been violence and there's ongoing violence, there's historical violence. There may be racism or disproportionality that exists in their relationships, in their communities. People have different levels of social support. And it's not just whether the support exists. It's whether it is helpful, what type of support it is, and is it utilized that's important.

And then we have communities that have different social priorities. And some of those may feel harmful or create conditions that people might view as dangerous. And this creates a condition where they may not feel physically or psychologically safe.

There's also the organizational context. And so this is the type of work that you do. We do know, for example, in some studies, some that I have done, we're seeing differences in, for example, those that work in child welfare types of context and those that might work, for example, in a school, with child welfare workers reporting higher levels of secondary traumatic stress. But again, that's really about dose of exposure and how much graphic trauma material you're exposed to.

The organization plays a role here. And so we want to know how STS-informed the organization is and the degree to which the organization is promoting resilience and creating safe, both physically and psychologically, workplaces and also how the organization is being impacted by the socioenvironmental context that I just described. So if this organization itself is under attack because of funding or social attitude or how others might prioritize the population being served, that has an impact on, again, how resilience-building and STS-informed the organization is.

We also know that if we're thinking about secondary traumatic stress, while we understand that that's a condition that's different than burnout and moral distress, these things can coexist. And that just complicates our recovery or our ability to be resilient in the moment, when we're also dealing with moral distress or emotional exhaustion related to working long hours and being under resourced.

And then we all have our own set of protective and response factors. So we may, more or less, have been raised in situations where we had secure adult relationships that have taught us how to use relationships for coregulation. We may have more or less presence of factors that promote resilience in our lives, such as high self-efficacy, being attached to something that brings meaning in our lives, being devoted to something bigger than oneself.

And then also, we may have in our toolkit, our coping toolkit, practice strategies that we're able to enact in the moment. And there is some suggestion in the literature that time, years of experience, can actually be

protective because people have had more opportunity to kind of sharpen their saws and have a nice full toolkit to deal with distress.

So we're going to use this window of tolerance model to talk about how we can manage these things in the moment. So if we think about our window of tolerance, it's kind of like the parameters by which we can stay regulated. And so if we think about our window of tolerance, we know that, when we're inside, what we can tolerate given our skill set, that we are very emotionally regulated because we're in our comfort zone, and we're able to be calm, cool, and collected because we are within the bounds of what we can tolerate. And because of that, we feel very connected to other people.

We're able to self-regulate because the alarm in our brain, our sense of danger, has not overwhelmed our capacity to cope. So we're able to self regulate. We could stay in this window of tolerance because our skill set is just what we need. And of course, you all know that when you're regulated, you're calm, cool, and collected, you have these nice, healthy relationships with other people because when we move outside of our window of tolerance and we become hyperaroused, so our stress response is activated, and we go into fight or flight, then we can become angry and rageful, overwhelmed.

We might be more aggressive in our language, in our behavior. We might have outbursts. We might be more impulsive and chaotic. And there may be more rigidity. In fact, I see this rigidity in people as a response to feeling out of control and threatened. So we kind of want to hold on tightly.

And so we know that when we're this type of state, that we're not a lot of fun to be around. So our relationships are affected, and we may be having some conflicts with our peers, with our family members, with our neighbors, our community members. And it's not just hyperarousal. We know that another stress response is freeze. And this is when we go into a hypo-aroused state.

And that is just as dangerous, though it is more difficult to detect. As you know, we may feel we're unavailable emotionally to other people. We shut down. We disconnect. Some people in the most extreme form may dissociate, which means that they just numb out to a point that they don't even-- they're not even connected to what's happening. They separate themselves, their feelings and their emotions, because what's happening is too overwhelming for them.

You know these people because they're flat in affect. That's their countenance is flat. They don't display a lot of emotion. They're kind of just going on autopilot. And some people in this extreme form may report memory loss as well.

So some of the things that take us outside of our window of tolerance are things that happen naturally in the workplace, when you're dealing with folks who have trauma histories and may be suffering with traumatic stress symptoms-- so high doses of indirect exposure. So you happen to be in a study, for example, where you're doing lots of interviews with victims of violence, with individuals who have PTSD or have trauma experiences, and the nature of your questions, of your research protocols, it means that you have to dig down into these details so that you can make coding distinctions and that you can capture their experience or code their experience.

Feeling physically or psychologically unsafe-- so we all know what it means to be physically unsafe. You might be doing research in a highly volatile situation, or you may feel psychologically unsafe because you may have begun to think that this work is not safe for me. And so you may feel very unstabilized by that-- repeated loss or threat of loss, perceived loss of control, and high exposure to trauma reminders.

So I was just going to let you take maybe just a minute here, and we're not going to spend much time in this space, but just wanted you to go ahead and identify three stressors that you might currently be experiencing, and just write about that. And then I just want you to reflect on do you see signs of hyperarousal or hypo-arousal. So just take like 60 seconds to do this. I'm not going to ask you to share it. It's just for you.

So I'm really asking you to do this because it's important to pay attention to how much time you stay in your window of tolerance and how much time you're outside of it because this self-awareness is what allows us to enact the skills and strategies we need. And if you're thinking about screening from a more organizational perspective, it's really important that you don't just screen people and then don't do anything about it and that people are screened in a way that's private and that they are not disclosing to their boss or anyone around them how they're feeling and what their scores are. We really want this to be normalized and validated as a normal occupational hazard.

So there are a number of tools that could be used to do this. And I'm just going to tell you quickly what they are. And then I'm going to tell you how to get to them. So the secondary traumatic stress scale, it maps right on to the DSM-5 categories. The ProQOL has a burnout, compassion satisfaction, and compassion fatigue scale. And then the moral distress scale targets both internal and external threats to what we think is right and what the barriers might be. And we have adapted that for use with fields outside of just healthcare.

And then there is this organizational assessment, the STSIOA, which is also a free assessment. And this is an organization assessment that you can use to track how STS-informed an organization is. We have a number of initiatives that we use to help organizations then start their journey to being STS-informed.

And Shoshana is going to put some of these links I'm going to show you in the chat so you can get right to them. But the first one is the-- sorry, I think I got muted. You can go on and take this STSIOA for free and get your scores. It'll give you a little chart, tell you where your strengths and weaknesses are.

So there's a number of ways that you can address occupational distress. I've got 12 strategies on here. And because of time, I can't go through every one of them. But I did want to highlight just a few ways that you can, in real time, address secondary trauma. And the first is through self-monitoring. And this is to really pay attention to how you're feeling. And this website that I have on the screen are some free anonymous screeners that include those that I just shared with you, the STS, the burnout, the moral distress scale, that you can go on. You can take these. It scores it automatically for you.

Nobody has your name. This isn't shared with anyone. It's completely private. And then it gives you resources based on your score. And so you can find that at this website here. You would just click on the box that was relevant to the one you wanted to take. And you can do that as many times as you want.

The second way we address occupational stress is to manage our trauma inputs. And so one way we do this is through our low impact processing method. And that is to be very aware when you're feeling dysregulated at work so that you can identify when you need to talk to someone. You need to go to them and give fair warning. So you say, hey, I've had a really bad qualitative interview. I'm feeling kind of distressed. I'd like to talk to you.

Get consent. Is it OK if we talk right now? Maybe it's not. Maybe they just had their own difficult interview. And then if they consent and say yes, then we only share what we feel, not what we heard. So when you hear something horrific, you don't really want to repeat all those graphic details. But what you do want to say is, "I don't know how I'm going to sleep tonight with all this in my head. I don't know how I can live in a world where people treat people with disabilities in this way. I don't know what to do with these feelings of anger that I have," for example.

Those are the things you want to talk about. So this low impact processing approach allows you to do that without sliming the other person and spreading the indirect exposure around.

Marking boundaries is to leave your work at work. So people have rituals. They touch the door frame as they walk out of their office and say it's done. They say the day is over. They may have a shutdown ritual. If you're working from home, you leave your work in another room, and you don't go back in there until it's time to work. So we mark our boundaries to separate ourselves from our work so we can get some space.

We cultivate a self-other perspective by trying to allow ourselves the time and space to think about what portions of this encounter are ours and what belong to the person that we talked-- that we've just talked to. What do we need to carry, and what is theirs to carry. And this is about organizing our own experience And as we kind of allow other people to do the same. And then being our own story editor. And this is really just thinking about not just the work or the research project that you're working on, but really writing down our story and then asking ourselves some questions about, is this true, these thoughts I have about my work? Is it helpful to have this thought? What does the story in my head sound like, and what does it mean with regards to my professional role and my effectiveness? And what sentences and what part of the story do I need to rewrite or replace?

And then finally, we do need some professional help. And these are some interventions that are long tested. Part of the trauma literature, we have three decades to tell us these things work. And our peer support strategies, such as STS-informed intervention and supervision. And this is-- there is a whole link to a process on how to provide STS-informed supervision and what the core competencies are.

My center does a free training for people who want to learn these. And we will provide that link to you as well. Some people use resilience buddies as a part of this.

And then finally, I encourage you to build your own individual plan. Look back at some of those challenges you might have written down early and think about what are some of the individual and peer support ways I could address these things. And do this with yourself. You can share it with a trusted peer. You can keep each other accountable. That's the resilience buddy approach.

And then finally, just encourage you to be compassionate to yourself and the people that you work with because one of the-- there's a quote I heard by Miller that said, "You never know what's going on down there where bones meet flesh--" what people's experiences are and what they're carrying. So I'm going to stop, and I'm going to leave this up just for a second. And I want to invite Allison to jump in and ask questions or provide her reflections.

ALLISON TAYLOR: Thanks, Ginny. That was great. And there were a few things that I was thinking about before the presentation that you ended up covering. So first, just a self-description-- I am also a middle-aged white woman with-- I have straight brown hair and a blurred background. And as Kathleen had mentioned, I'm coming at this as a researcher in the disability space. I've done some research on trauma. And-- but most of the research I do doesn't necessarily directly involve asking people about their traumatic experiences. Even when I do-- even when I do trauma-related research, I try not to ask people directly about their trauma experiences because usually the questions I'm asking are more about coping or about experiences with services.

But I'll say that, even in circumstances where we are doing research that doesn't involve directly, we're not necessarily talking about trauma. But we are asking people to tell us their experiences with maybe disability services, their needs, the barriers they encounter. People might bring up a whole host of things that we may not expect.

In my experience, people can sometimes share about their disability story, how they acquired their disability, which might include violence or traumatic experiences that you may not be able to expect. They may also share experiences of ableism, racism, other forms of identity-based abuse, which can be traumatic. So I think there's a few things that I would also just add as a disability researcher, just to think about your positionality and think about who-- what are your identities and what are you what are your experiences that, if you are to hear something, what might potentially trigger you? What might potentially be something you might relate to? Sort of using time to prepare and expect-- especially, again, if you're sharing identities with your interviewees, as a person with a chronic illness, there are things that people might bring up that could affect me personally in ways that it might not affect another researcher.

And so those were a couple of things I was thinking about. And Ginny, I know you mentioned some of the issues that I also would think about in terms of how to manage and how to prepare and how to respond to your trauma responses when doing research. I'm wondering if you have any thoughts about the sort of informed consent process and how that might contribute to sort of trauma-informed research. Because I know-- you know, I think about using trauma-informed research methods can both help the participant and I and I'm thinking a lot about interviews. That's what you talked about too because that's a lot of what I do.

So it can help the research participant. But it can also help the individual that's conducting the research. so using those things, like being transparent, accessing peer support, having clear boundaries, both for yourself and sort of setting up the interview with boundaries. I'm wondering if you have any other thoughts about that.

GINNY SPRANG: Yes. I'm so glad you brought that up, Allison, because there is this movement for systems for researchers, for organizations to become trauma-informed. And so we do learn these principles that Allison was referring to, these trauma-informed principles about safety and voice and choice and transparency and collaboration and cultural competency. But what is ironic is we learned so much about applying these to our clients that we learn that quite often organizations don't apply that to their workforce. And so if you're sitting in a position where you feel like you have no voice or choice, when you feel like there's no transparency, where you don't feel like you're in a collaborative environment, where you feel like it's not culturally competent, then you may be experiencing the same kind of disequilibrium in your role that the research subject or the interviewee may be experiencing as well.

So, yes, I challenge organizations to think about how do we apply these trauma-informed principles to our staff because that provides protection. We very much feel like it is a collaboration between individual and organizational efforts to decrease secondary trauma. In fact, some of my research shows that as organizations become more STS-informed, levels of secondary traumatic stress do begin to decrease.

There's an article in the American Journal of Orthopsychiatry that talks about that.

ALLISON TAYLOR: Well, I think we're run out of time. I see, Kathleen, you've put your video on, so I'll hand it over to you.

KATHLEEN MURPHY: Sure. Thanks so much, Ginny, for a really chock-a-block full of information presentation, really a lot of food for thought. And Allison, I know you had taken time to look through the presentation ahead of time, so thanks for your very informed question. And we look forward to hearing more about your work maybe in a future presentation. So I know we don't have time for questions, but we may do a follow up event, perhaps thinking also about, obviously, the trauma that the communities themselves are experiencing and more along those lines, not only focused on the research teams themselves. So, if you can do the evaluation, that would be great. And there's a field in there where you can put in questions or suggestions for future training topics.

And so with that, I'll almost close. I do just want to do our-- let you know again that the contents of this webcast were developed under grant award number 90DPKT0001 from NIDILRR. NIDILRR, as I mentioned, is a center within the Administration for Community Living Department of Health and Human Services. The contents of this webcast do not necessarily represent the policy of NIDILRR of ACL HHS. And you should not assume endorsement by the Federal Government.

So I think with that, we can close. And we look forward to seeing you in our next one. Thanks all.