NATIONAL
Center on
Domestic Violence, Trauma & Mental Health

Understanding Traumatic Triggers

Traumatic triggers come in many forms. A trigger is a reminder of past traumatizing events. Many things can be a possible trigger for someone. For example, what seems like an "ordinary" request such as, "Make sure the children are ready for school on time," can be a trigger for a survivor whose abusive partner terrorized and punished her if the children were late for school. Part of our work is in changing our frame so that we always keep in mind that survivors' responses to seemingly neutral events and interactions with people may reflect a trauma response. Survivors may have adopted long-term patterns that reflect their efforts to adapt to a traumatizing life. We also work to hold in mind that this behavior and these patterns reflect strategies that survivors have developed to keep themselves safe—that is, they reflect strength and resiliency.

What Happens When Someone Is Triggered

We can understand how it might be for a survivor of a flood, like a survivor of Hurricane Katrina, who was swept away as water rushed into her house. We can understand how she might feel frightened when someone turns on a shower without warning—just the sound of sudden water may reawaken the old experience. In a similar way, a person who has experienced terroristic abuse and control by a partner or family member may be triggered by encountering a person in authority. A survivor whose abuser made and enforced "rules" in the house may feel anxious or frightened even by the words "shelter rules."

Can We Eliminate Triggers?

Once we become aware of triggers, we might feel an impulse to "get rid of all the triggers." Of course, we will avoid violent images or angry tones in our speech, keep video and film with aggressive content out of the common shelter areas, and try to make the environment calm. But there will always be trauma triggers that we cannot anticipate and cannot avoid. Part of trauma-informed work is supporting survivors as they develop the skills to manage trauma responses both in our shelter and elsewhere in the world.

Examples of Possible Triggers

Traumatic triggers come in many forms. A person might be triggered by a particular color of clothing ("*My batterer always wore a plaid jacket home from work, and that's when he would come after me*"), by the smell of a certain food ("*I was cooking taco meat when my batterer attacked me*"), or even the time of year ("*When it snows I remember the night I got pushed out into the snow in my nightgown*"). Encountering such triggers may cause us to feel uneasy or afraid. Sometimes we know why we are feeling a certain way and other times we aren't sure why. Recognizing when we are being triggered is an important part of building the skills to manage our trauma responses.

Impact of Trauma on Interaction and Engagement: Information Sheet for Domestic Violence Advocates[*]

Trauma can affect a survivor's…

- Interactions
- Stress tolerance and ability to regulate emotions
- Responses to negative feedback
- Ability to screen out distractions

It could look like…

- A survivor seeming "cool" and detached
- A survivor who is highly sensitive and whose feelings are easily hurt
- A survivor is suspicious and not trusting
- A survivor does not "read" or trust warmth and caring from staff and other survivors

When someone is experiencing a trauma response, she may…

- Not be able to talk to you about what is happening
- Not notice what is happening
- Not know what will help or think that nothing will
- Need some time alone or be comforted by having you near
- Feel too upset or overwhelmed to interact with you
- Not want to say what she needs because she does not feel safe enough, she may want to protect you, or she may believe that she should not say

Connection and Reflection Skills:

We know that any survivor may have difficulty engaging with an advocate who offers to help her. It is important to develop communication skills that acknowledge a person's trauma-related barriers to communication, while also following the survivor's lead in the conversation. We can do this by using two sets of skills—our connection skills and our reflection skills. Our connection skills include our ability to engage, be available, be present, convey empathy, avoid judgment, and be open and honest about what we are offering. We sometimes think of these as "lifelines," meaning that they may not be picked up immediately but are available when the other person is ready. Our reflection skills include our self-awareness and responsibility for understanding our own needs and reactions, both of which help to sustain our connection skills.

---

[*] This handout is adapted from *Access to Advocacy: Serving Women with Psychiatric Disabilities in Domestic Violence Settings: A Curriculum for Domestic Violence Advocates*, National Center on Domestic Violence, Trauma & Mental Health, Chicago, IL (2007).

CREATING TRAUMA-INFORMED SERVICES: TIPSHEET SERIES

Tips for Creating a Welcoming Environment

The environment we create communicates our beliefs about the people we serve. This environment and the way we offer services are critical aspects of our work to increase access to our programs for women who are experiencing psychiatric disabilities or the effects of trauma. Most of us understand what it feels like to be welcomed. It's the feeling that comes when we have a sense that people want to have us around and that the environment is set up in a way that is comfortable for us.

The environment we create communicates our beliefs about the people we serve.

Offering welcome may mean giving food or drink to a guest, providing a comfortable place to sit, or making sure that the room is not too hot or too cold. In DV programs, we may convey our welcomes by choosing our language thoughtfully (e.g., saying "survivor" rather than "victim" or "client") or by selecting art that reflects the cultures of the communities that we serve. In creating a welcoming environment, it is important that we attend to both physical and interpersonal aspects of our program.

1. Offer trauma-informed services.

> *"Our support groups and individual meetings are intended to help you increase safety for yourself and your children and to help you find and use your best resources so that you can have the kind of life that YOU want to have."*

Offering trauma-informed services recognizes the pervasiveness of trauma and its impacts on a survivor's ability to cope, to access our services, and to feel safe in a new environment. When your services demonstrate that staff are comfortable with many kinds of behavior and a wide range of needs, this lets a survivor know that she is welcome *as she is*. Thus, offering trauma-informed services is a critical component of creating welcoming environments in DV programs. We offer trauma-informed services when we:

- Become knowledgeable about trauma and participate in ongoing training on how to offer trauma-informed support.
- Recognize that responses to trauma may include a numbing of feelings, a desire to avoid things that are reminders of previous traumatic experiences, and an increased sensitivity to these reminders, to people, and to the environment.
- Provide information to survivors about trauma and its effects.
- Offer flexibility and choices when possible as to how a survivor can interact with our programs and our staff.

- Take seriously a survivor's trauma responses (e.g., she may be jumpy or anxious, she may have a hard time sleeping, or she may need to avoid a neighborhood that has too many reminders of past experiences).

2. Understand symptoms as adaptations.

> *"We work hard in our program to make sure that each person is able to make choices about how she contributes to the community while living here. We understand that people have different ways of doing this."*

In trauma-informed settings, we see a survivor's behavior as reflecting adaptations to a world that has not always been safe. Instead of trying to fix a person's behavior, we begin with an understanding that many factors (including a person's genetic tendencies, brain chemistry, and life experience as well as the person's current environment and access to resources) affect how the world looks to her, what feels safe, what she thinks may happen, and how she asks for and uses our services. If a survivor has a mental illness, she knows that she neither has to hide that she has a mental illness nor disclose it in order to get the help she is seeking. Of course, this does not mean that we will not have reactions if a person's behavior is troublesome, disrespectful, or dangerous. It does mean that the way we communicate our reactions should not shame or embarrass a person. Saying, "We want everyone to be safe and comfortable here. You have been shouting for a while and that worries some of us," is better than saying, "You can't keep making all that noise—you need to sit down and be quiet." Both statements let the survivor know that people are reacting to her behavior, but the first is respectful and acknowledges that the survivor is doing the best that she can.

3. Adapt the physical space.

> *"We have different kinds of spaces here in the shelter—a room where people can sit quietly to collect their thoughts, safe spaces outside to work off some energy, and an area stocked with art supplies for people who want to draw or paint to express themselves."*

When we arrange the physical environment to accommodate a wider range of feelings, interactions, and behavior, we make our programs more accessible to all. If the program staff recognize that anyone might want a quiet place or need to move around more, or that noise or very cluttered environments can be unsettling, it communicates that a wide range of people are welcomed and wanted in your program.

For more information or for technical assistance, please contact the National Center on Domestic Violence, Trauma & Mental Health at info@nationalcenterdvtraumamh.org or 312-726-7020(P) or 312-726-4110(TTY).

NATIONAL Center on Domestic Violence, Trauma & Mental Health

CREATING TRAUMA-INFORMED SERVICES: TIPSHEET SERIES

Practical Tips for Increasing Access to Services

Domestic violence, lifetime abuse, and trauma can significantly impact a person's mental health and well-being. Experiencing abuse can affect how a person feels, thinks, and interacts with the world. Sometimes, trauma-related mental health symptoms improve with increased safety and support. Other times, the mental health effects of trauma may be long-lasting or may develop into a psychiatric disability. People with a psychiatric disability are at a greater risk for abuse and may also experience an exacerbation of symptoms as a result of being abused.

As advocates, we know that survivors come to our programs with many diverse needs. We can take steps to ensure that our program is accessible to all survivors, including survivors who are experiencing the mental health effects of trauma or psychiatric disability. Think about how your services might be experienced by someone who has experienced trauma. Remember that abuse can affect how a person feels, thinks, and interacts with the world.

Ask yourself…

1. How might this make someone feel? What are some ways that I can support survivors to manage feelings?

Describe common effects of trauma and domestic violence on feelings; reassure her that she's safe and that she's not alone; **offer calming words**, deep breathing, and **other grounding techniques**; describe things that I am doing to help keep her safe; have flexible policies about locks and lights; work with her to redirect energy; **offer calming distractions or diversions**; discuss the impact of past impulsivity; help her to understand, anticipate, and plan her response to future triggers; **keep her company**; remain calm myself; reassure others; ask what matters to her; ask about hopelessness; don't blame her.

Additional strategies I can use…

2. Is information provided in ways that a person can understand easily? Are choices offered thoughtfully? What are some ways that I can support survivors around thinking, processing, planning, and energy level?

Remember that she guides the speed of the discussion; be willing to present information slowly; **simplify choices**; explain clearly; be willing to repeat myself; ask about disturbing or unwelcome thoughts; **reduce excess stimulation**; ask about suicide; offer realistic options; offer my realistic optimism; don't challenge unrealistic beliefs but respond to the fear, worry, or distress; **break down plans into small steps;** pace schedule and expectations; have flexible programs and plans; offer breaks; **celebrate everyday accomplishments;** ask directly about sleep disturbance; offer an alarm clock or wake up calls.

Additional strategies I use…

3. How is she experiencing my interactions with her? How is she experiencing interactions with others? How can I support her around interacting with others?

Keep a respectful stance; **validate conflicting feelings;** affirm senses of urgency; **only promise what I can deliver;** be honest about personal and program capacities and limitations; be clear about your expectation of safe behavior; offer food, tea, and routine activities; **model values of mutual safety and respect**; offer breaks from the interaction; give space; remain engaged myself; notice when my feelings are getting in the way of the interaction and **take breaks for myself.**

Additional strategies I use…

For more information on the intersections of domestic violence, trauma, mental health, and substance abuse, contact the National Center on Domestic Violence, Trauma & Mental Health at (312) 726-7020, 312-726-4110 (TTY), or info@nationalcenterdvtraumamh.org.

CREATING TRAUMA-INFORMED SERVICES: TIPSHEET SERIES

Tips for Enhancing Emotional Safety

As DV advocates, we are skilled at attending to physical safety in our programs. *Emotional* safety may seem more difficult to achieve because it is harder to measure. One definition of emotional safety is "a feeling that your inner most thoughts, feelings and experience are, and will be, honored as one honors themselves. You need not prove, nor impress; you just simply are. When it is present you feel open, even, at ease, and fluid with the spontaneity of a healthy child."[*] There are several steps that we can take to increase emotional safety in our programs.

1. Understand emotional safety.

> *"We want you to know that whatever you are thinking and feeling, you are welcome here."*

Emotional safety means feeling accepted; it is the sense that one is safe from emotional attack or harm. Most survivors have probably felt emotionally unsafe or had their sense of "being all right" taken away. Many survivors tell us that the ongoing and unrelenting attacks on their sense of well-being are more painful than a beating. When a survivor has been traumatized, she may not be able to find her way back to a day-to-day sense of calm and safety even after she and her children are physically safe and cared for.

Being sensitive to the feelings of survivors is a key aspect of what we do.

2. Help survivors manage feelings.

> *"For many women, this can all be overwhelming. We don't have to solve every problem right away. Let's take the time to sort things out together and then decide which thing you want to work on first."*

Trauma may affect a person's ability to find emotional balance. Survivors may experience a flood of feelings and worries that make it difficult to make decisions, follow plans, and tend to responsibilities. Providing for the emotional safety of survivors is an important part of our work as DV advocates.

---

[*] Jeanne King, PhD, *Emotional Abuse: The Lack of Emotional Safety as an Internal Indicator in Abusive Relationships*, http://www.preventabusiverelationships.com/articles/emotional_safety.php.

Our work is not only to reassure and comfort survivors but also to activate and engage the thinking processes that can lead to greater safety and control. This may mean offering a caring and calming presence, helping with tasks that are overwhelming, working to identify achievable goals, offering frequent breaks, and tailoring program expectations to the individual survivor.

3. Provide a soothing place.

"You may just want to sit and relax for a bit. This room is set up for that and open whenever you need to use it."

When we provide a calming space, we are telling each survivor that we care about how she feels and that we are interested in what happens to her emotionally as well as physically.

A soothing space may be nothing more than a corner of a quiet room, set aside for survivors to use to care for their feelings or to help restore a feeling of calmness. It can be as simple as a comfortable chair, a soft afghan, low lights, a door that can be closed or kept open, a source of quiet music. Or it could be a more elaborate room with plants or flowers, videos of beautiful scenery, stuffed animals to hold, a radio or CD player, and space for writing, praying, or exercising. Different things will be soothing at different times and to different survivors.

4. Provide information about trauma.

"Many people have trouble turning their minds away from frightening experiences. Sometimes people feel anxious, worrying about how to make things turn out better."

Trauma can disrupt a person's sense of well-being. It can also have direct effects on the brain, changing how the person experiences the world and how she perceives danger. Some survivors find it helpful to hear that trauma responses are real and that they "make sense." Learning about trauma triggers can help survivors understand and manage their feelings and can increase a survivor's sense of control and autonomy. Advocates can provide this information through conversations, exercises, classes, posters, handouts, and videos.

5. Provide clear information and avoid surprises.

"A lot of us live and work together in the small space here. That's why we meet twice a week to talk about how things are going for each of us and what we each

> *need to be as comfortable as possible. We ask all the community members who live or work in the shelter to be present."*

When a person feels emotionally unsafe, it may feel hard to not know what the people who have power, authority, and information are going to do. Providing clear and accurate information about policies, procedures, rules, plans, and activities helps support emotional safety. If our programs let survivors know how we do things and how decisions are made, if we are clear about the rules that the staff follow, and if we actually do what we say we are going to do, we avoid surprises.

6. Help survivors feel comforted and in control.

> *"We want you and your children to feel safe and welcome. If something doesn't seem right to you, please do let us know and we'll work on it with you."*

Each survivor has her own pattern of needs related to emotional safety. For example, one survivor may find it reassuring to have clear directions or information from staff who speak with authority and expertise. For someone else, being able to withdraw from external stresses to explore her own thoughts and feelings will be the jump start she needs to plan for her future. An important aspect of helping survivors feel comforted and in control is ensuring that survivors know that they can ask for what they need and express their opinions and wishes, even if they are different than what the program is offering or what other survivors are doing.

7. Support emotional safety for staff as well.

> *"All of us are affected by the work we do. Everyone's emotional safety is important."*

DV program staff need to feel emotionally safe themselves in order to support survivors' emotional safety. Every tip on this sheet applies to staff as well as survivors. Program leaders should understand how doing DV work affects staff members' feelings, energy, and worldview. Clear policies, honest communication about our plans and processes, ongoing training, and supportive supervision are important aspects of emotionally safe environments for staff and allow staff to offer their best to survivors.

For more information or for technical assistance, please contact the National Center on Domestic Violence, Trauma & Mental Health at info@nationalcenterdvtraumamh.org or 312-726-7020(P) or 312-726-4110(TTY).

NATIONAL
Center on
Domestic Violence, Trauma & Mental Health

CREATING TRAUMA-INFORMED SERVICES: TIPSHEET SERIES

A Trauma-Informed Approach to Domestic Violence Advocacy

Adopting a trauma-informed approach[*] to domestic violence advocacy means attending to survivors' emotional as well as physical safety. Just as we help survivors to increase their access to economic resources, physical safety, and legal protections, using a trauma-informed approach means that we also assist survivors in strengthening their own psychological capacities to deal with the multiple complex issues that they face in accessing safety, recovering from the traumatic effects of domestic violence and other lifetime abuse, and rebuilding their lives. It also means ensuring that all survivors of domestic violence have access to advocacy services in an environment that is inclusive, welcoming, destigmatizing, and non-retraumatizing.

This document will discuss **five core components** of a trauma-informed approach to domestic violence advocacy. These include (1) providing survivors with information about the traumatic effects of abuse; (2) adapting programs and services to meet survivors' trauma- and mental health-related needs; (3) creating opportunities for survivors to discuss their responses to trauma; (4) offering resources and referrals to survivors; and (5) reflecting on our own and our programs' practice.

1. Provide survivors with information about the traumatic effects of abuse.

Many survivors of domestic violence will not be familiar with the concept of trauma. Some survivors may believe that it is a sign of strength to be able to withstand extreme difficulty without complaining. Some may view silent endurance as a religious or spiritual value. Helping survivors understand that there are natural ways that the human mind and body respond to stress and pressure can help counter the belief that these reactions are signs of weakness.

How can your programs provide survivors with destigmatizing information about the traumatic effects of abuse?

- Discuss the link between lifetime trauma, domestic violence, and mental health.
- Discuss some of the common emotional or mental health effects of domestic violence and ways that these responses can interfere with accessing safety, processing information, or remembering details.

---

[*] The notion of "trauma-informed services," which comes from the work of Maxine Harris, PhD, and Roger Fallot, PhD, at Community Connections, is designed to promote recovery and minimize the chance of revictimization. Harris, M. & Fallot, R. (2001, Spring). *New directions for mental health services, Using trauma theory to design service systems*, *89*, Jossey-Bass.

- Discuss the ways that trauma can disrupt our ability to trust and to manage feelings and can affect the ways we feel about other people, ourselves, and the world.
- Discuss the things that abusers may do to make their partners feel "crazy."
- Discuss the ways that abusers use mental health issues to control their partners.

2. Adapt programs and services to meet survivors' trauma- and mental health-related needs.

As domestic violence programs become sensitized to the effects of trauma and the need to provide inclusive services, we can work to create programs, policies, and settings that meet survivors where they are and that are careful not to retraumatize survivors.

How can your program respond to the individual needs of survivors?

- Conduct pre-intake screenings for domestic violence only and do not "screen out" for mental health "issues" or a history of psychiatric treatment.
- Create a welcoming environment with a wide range of options for survivors and make changes when practices and policies are not well suited to individual survivors' needs and capacities.
- Discuss ways that shelter living can be difficult for everyone and offer supportive strategies that would make it more comfortable for the individual survivor with whom you are working.
- Have a standard medication policy for everyone. It is not necessary to know what medications women are taking or why. Questions related to medication may be prohibited by law. Please see the Center's *Model Medication Policy* for further guidance.
- Inform survivors about your medication policies and let her know you are available to discuss any particular needs she has (e.g., she has run out and needs new supply, is having problems with side effects, is not sure they're helping, can't afford them, etc.).
- While conducting support groups or house meetings, discuss the range of responses people have to trauma, including physical and mental health symptoms.
- Reassure and support survivors who are uncomfortable with the mental symptoms of other women in the program that these are common responses to abuse.
- Collaborate (with consent) with the mental health providers, peer support specialists, and/or systems that work with each individual survivor.
- Inform or educate the mental health providers on issues related to domestic violence, including documentation of abuse in mental health records and additional needed supports.

- Advocate with mental health providers and systems on behalf of survivors when requested and support survivors in their efforts to advocate on their own behalf.

3. Create opportunities for survivors to discuss their responses to trauma.

Once survivors are aware that most people have natural responses to extreme stress and pressure, it may be possible to help each woman to think about the specific ways that she and her children have managed, responded to, and been affected by the stress, pressure, and trauma that they have experienced.

How can your program provide opportunities for a survivor to discuss her responses to trauma?

- Ask about ways that she has changed as a result of the abuse.
- Ask if she is having any feelings or thoughts that concern her.
- Ask about the impact of domestic violence on her emotional well-being and mental health.
- Attend to the role of culture, community, and spirituality in her life.
- Talk with her about how her own emotional responses to abuse can affect how she responds to her children and offer strategies for noticing and addressing those concerns.
- Ask if her abusive partner interfered with past mental health treatment or medication.
- Ask if she has any mental health concerns she'd like to discuss, including concerns related to treatment, medications, hospitalizations, or past interactions with mental health providers or mental health systems.

4. Offer resources and referrals to survivors.

Like many of us, survivors of domestic violence may hold stereotypes about mental health treatment. Survivors may be unfamiliar with mental health services, believe they are only appropriate for people with very extreme symptoms, or think they are indulgences for weak or pampered people. You can let women know that these resources are appropriate for anyone who has been highly stressed or traumatized—that everyone deserves to feel better. Resources may include self-help tools as well as referrals to knowledgeable providers in the community or consultants who provide services at a DV program.

How can your program make resources and referrals available to a survivor?

- Discuss the process of healing from abuse and other trauma (instilling a sense of hope, that she will not feel this way forever).
- Develop culturally relevant and community-based referrals and linkages.

- Let her know that if she is interested in accessing resources and services related to healing from abuse and other trauma, you can help her to access them.
- Provide linkages to information or resources to help her advocate for herself around mental health or medication issues (or, with permission, advocate for a survivor with her mental health care provider).
- Work with her on strengthening or developing new skills for dealing with painful or disruptive feelings such as relaxation training or exercises,[†] grounding techniques, affect regulation strategies, or developing a written plan like a Wellness Recovery Action Plan (WRAP®).[‡]

5. Reflect on our own and our programs' practice.

Being aware of our own reactions to others and to trauma helps ensure that our interactions with survivors are focused on supporting their best interests and well-being. Reflection also helps us to make thoughtful and professional decisions with knowledge of how our personal reactions and feelings are operating.

How can your program incorporate reflection into your practice and your settings?

- Create an environment with regular opportunities to reflect on your responses to each individual survivor and how those responses may be affecting her, as well as what those responses may reflect about your own experiences.
- Reflect on the impact of the work that you do on your own life (i.e., how you experience secondary trauma) either privately or with trusted others (including supervisors, peers, therapists, family, friends, etc.).
- Work with colleagues to recognize the ways in which tensions that arise within your program (among women receiving services and among program staff) may be related to staff feelings about and reactions to trauma. Develop ways to safely and respectfully address these issues when they arise.

For more information or for technical assistance, please contact the National Center on Domestic Violence, Trauma & Mental Health at info@nationalcenterdvtraumamh.org or 312-726-7020(P) or 312-726-4110(TTY).

[†] For example, see the Capacitar Emergency Response Tool Kit (available in multiple languages) at http://www.capacitar.org/emergency_kits.html

[‡] For more information about WRAP®, see http://www.mentalhealthrecovery.com/aboutwrap.php

Handout for Module 3 –
Understanding the Impact on Advocates and Advocacy

Understanding Our Own Responses

Understanding Transference

Transference and countertransference are two clinical terms that can be helpful in understanding human interactions. Transference and countertransference are ever-present. The more we are aware of when they are at play, the easier it is to understand any interaction that we find challenging. Part of what these concepts are based on is an understanding of how we internalize (through all those complex and ever-growing neural pathways) the experience of ourselves in relationships, particularly to the people who are most important to our development, whether in positive or traumatic ways.

What we carry with us are not just our memories of the other person (how they were, how they looked, how they smelled, how they treated other people, how they treated us, including how they saw us), but also how we experienced ourselves in that relationship and what it was like between us. In other words, we carry both sides of those relationships with us, various aspects of which can be evoked in interactions with other people.

Transference refers to the responses we have to other people that are based on who they remind us of from our past, rather than who they actually are. Transference and countertransference are by definition unconscious responses (i.e. happen out of our conscious awareness). The first inkling may be that something feels off in our interaction or doesn't make sense, or we do not feel like ourselves, or our responses to a particular person do not really fit or seem out of proportion to the situation. Sometimes our interactions involve a combination of both – we are responding emotionally to a person as if they were someone from our past, but intellectually we are fully aware of who they are in the present.

The point in talking about transference and countertransference is that once we become aware of them, they become important tools for understanding ourselves and other people. And, when we are not aware, these responses often get in the way of those interactions.

An example:

> *I find myself being really drawn to an older woman who just came to our shelter and wanting to spend as much time with her as possible. In discussing this with one of my co-workers, I realize that she (or her perfume) reminds me of my grandmother who was the person who was most supportive of me growing up.*

Why are these issues important to our work?
Domestic violence advocacy is unique because the *quality of our presence* is central to the work we do. The relationships that we establish with survivors are both the tools and the goals of our work.

Just as singers need to tend to their voices (their central instrument) and athletes need to tend to their bodies (their central instrument), advocates need to tend to our psychological and emotional selves in order to do our work well. We matter. What we bring to the work, how aware we are, who we are, what we mean to those with whom we work, how present and empathic we can be—all of this matters to the survivors we work with. The flip side of this is that our work matters to us. When our emotional and psychological selves are our primary instruments, then the work can take a toll on these instruments.

We need to be aware of the potential effects of trauma work and to care for our instruments accordingly. Tending to ourselves as our primary tool or instrument entails professional, ethical, and personal responsibilities. This focused attention requires an acute sense of self-awareness and follow through on all aspects of caring for physical and emotional wellbeing.

When our own lives are out of balance and when we are unaware of our own stress and distress, then we increase the likelihood of boundary violations. We may unintentionally do harm by failing to address issues that arise in our own interactions with survivors, particularly if they interfere with our advocacy work.

Examples:

- Becoming overly involved in ways that go beyond our role as advocates
- Getting involved in ways in ways that are meeting our own personal needs
- Getting involved in ways that may ultimately be harmful or undermining to the person we're working with and may increase the risk of other harm to survivors (Pearlman and Saakvitne, 1995)

Many people who have survived interpersonal trauma live with the fear that they will harm others through their needs or feelings. Many survivors will attempt to take care of advocates before they take care of themselves. We do people we work with a disservice if we neglect to protect and care for ourselves.

Engaging in respectful, collaborative relationships is not always easy. It takes consistent attention, awareness, and negotiation. When we fail to tend to ourselves, we may be more likely to respond to survivors in ways marked by distance and disconnection, which may then decrease the likelihood of the relationship being able to provide the foundation for the work that happens in the context of domestic violence advocacy.

For example, when overwhelmed, overburdened, and under supported we may:

- Be more likely to fall back on an "us and them" mentality that works against both connection and empowerment.
- Blame survivors for struggles we are having.
- Become shut-down in the face of organizational conflict.
- Be more likely to act without reflection.
- Be more likely to fall back on rigid rules and emphasize control over a problem, or person, rather than collaborative planning to address the issue.

All of these coping strategies work against the principles of effective support and advocacy. This does not mean that providers should never be overwhelmed, overburdened, anxious, or otherwise upset or distressed. Whereas this is a wonderful ideal, it is not realistic. Of course, we will feel such things from time to time. Being professionally responsible to the survivors we work with, however, entails being aware of when we feel distressed and having strategies to address this.

Understanding Secondary Trauma

Another factor to consider in understanding our responses is to think about and look at the ways that our work affects us and to attend to its impact. We often call this impact “secondary trauma.” Another way to view this is as the cumulative inner transformative effect of bearing witness to abuse, violence and trauma in the lives of people we are open to. When we allow ourselves to be open and attuned, open to other people’s experiences or to partner with others, we too are affected. (Adapted from Saakvitne & Pearlman, 1996, Prescott 2003, Warshaw 2003)

Some ways that secondary trauma can show up in our work and lives:

- How we see and understand ourselves and how we see our world and relationships (world view). Optimism is replaced by a much more negative view about the world and people we encounter.
- We can become unsure of our connections to others and our effectiveness at doing things.
- We begin to question the meaning of our lives and whether we, our lives, and our work are worthy. We may experience an overwhelming sense of hopelessness and despair.
- It affect our spirituality, leaving us feeling adrift and uncertain.
- We can come to doubt our capabilities and, in fact, function in ways that are very different than what we are used to, becoming less efficient, less focused.
- Managing feelings can become increasingly difficult. All of the trauma responses we discussed in Module 2 can become responses we manage when the trauma is not our own but affects us deeply in our own lives.
- We can become too open or too raw and then pull away or emotionally shut down as a way to manage those feelings.

- Our judgment and capacity to do advocacy work is diminished.
- Our beliefs about ourselves and about others come into question. In addition to questioning the foundations of some of our most important relationships, we come to question whether we are physically and emotionally safe, can trust others, maintain intimacy, and are in control at work, at home, and in our communities. Withdrawing socially is a common response to managing these feelings.
- Secondary trauma can impact our bodies and overall physical health; for example how we eat, experience physical pain, exercise, and whether we take care of our personal health care needs.
- Perception and memory can be impacted, leaving us unsure of ourselves and our competence and suspicious of our capacity to be part of groups. We may wonder if we can do our part.
- Intrusive thoughts about work are common, not being able to shake preoccupation with the horror others have experienced and experiencing work related nightmares.
  (Saakvitne et. al. 2000)

by CHRISTINA MASLACH & MICHAEL P. LEITER

REVERSING BURNOUT

How to rekindle your passion for your work

PHOTOGRAPH BY DAVIES & STARR/GETTY IMAGES

MARK[1] IS EXHAUSTED. AS A COMMITTED ENVIRONMENTAL activist, he logs hundreds of pro bono hours every year organizing rallies, circulating petitions, raising funds, lobbying legislators, and campaigning for like-minded politicians. And that's not even his day job; Mark is also pursuing a full-time career to pay the bills.

"I'm feeling totally overwhelmed by the immensity of the problems we face," he says, "but I keep pushing myself. It's like an anorexic getting thin. When you're an activist, you're never working hard enough."

Lately, though, Mark's passion has been increasingly tainted with bitterness. "I sometimes look at the stuff I have to do and I get angry," he says. "Like, why doesn't somebody else do some of it? Why is it just *me*?" Mark is also disturbed to find himself muttering, "Oh, a pox on them" when he thinks about the communities he is trying to help. "They don't want to save themselves," he continues, "so why should I go out of my way?"

Susan is also bitter. After five years as an emergency department physician at St. Joseph Hospital, she still feels left out of the tight-knit team of ER staff. "I need to be included in discussions about patients, diagnoses, and interventions," she says, "and I need a meaningful voice in decisions on medical practice in this ER." Yet neither is happening.

The other doctors – all men – have extended their circle to include the ER nurses and assistants. But they don't seem to know what to do with Susan. Instead of treating her as their equal, they make important decisions without consulting her, disrespecting her status and abilities.

In turn, Susan doesn't know what to do with her male colleagues. "I can't get into the flirty banter that goes on between the male doctors and nurses," says Susan. "That isn't the way I operate, and it doesn't go with my responsibilities as a doctor."

And so recently, Susan finds that the usual aches and pains of a long day's work are now paired with a deeper, more troubling feeling: She just doesn't care about what she is doing. This dullness of heart scares Susan. If she can't count on her sensitivity to patients, she can't be confident of her work.

Both Mark and Susan are suffering from burnout. Far more than feeling blue or having a bad day, burnout is a chronic problem. Burned-out people often feel exhausted and overwhelmed like Mark, self-doubting and anxious like Susan, and bitter and cynical like both of them.

Burnout reflects an uneasy relationship between people and their work. Like relationship problems between two people, those between people and their work usually indicate a bad fit between the two, rather than *just* individual weaknesses, or *just* evil workplaces. And so reversing burnout requires focusing on both individuals and their organizations to bring them back into sync with each other.[2]

Beating burnout is not just a matter of reducing the number of negatives. Indeed, sometimes there is not a lot you can do about the negative aspects of work. Instead, it is often more useful to think about increasing the number of positives, and of building the opposite of burnout, engagement. When burnout is counteracted with engagement, exhaustion is replaced with enthusiasm, bitterness with compassion, and anxiety with efficacy.

"It's like an anorexic getting thin. When you're an activist, you're never working hard enough."

The Six Areas of Burnout

How do individuals and organizations move from burnout to engagement? How do they make sense of what's going wrong, and figure out how to make things right? Our surveys and interviews of more than 10,000 people across a wide range of organizations in several different countries have revealed that most person-job mismatches fall into six categories: workload (too much work, not enough resources); control (micromanagement, lack of influence, accountability without power); reward (not enough pay, acknowledgment, or satisfaction); community (isolation, conflict, disrespect); fairness (discrimination, favoritism); and values (ethical conflicts, meaningless tasks).[3]

CHRISTINA MASLACH *is a professor of psychology and the vice provost for undergraduate education at the University of California, Berkeley. She has conducted research in social and health psychology, and is best known as a pioneering researcher on job burnout and as the author of the widely used Maslach Burnout Inventory (MBI).*

MICHAEL P. LEITER *is a professor of psychology at Acadia University in Canada and director of the Centre for Organizational Research & Development, which applies high-quality research methods to human resource issues that confront organizations. He holds the Canada Research Chair in Occupational Health and Wellness at Acadia University.*

PHOTOGRAPH BY JUSTIN PUMFREY/GETTY IMAGES

We originally developed this six-category framework as a way of organizing the vast research literature on burnout. Our subsequent work then showed that both individuals and organizations could use the framework to diagnose which categories are especially troublesome for them, and then to design interventions that target these problem areas.[4] The six-area framework has now been incorporated into assessment programs for organizations[5] and for individuals.[6] (See sidebar on p. 48 for more about the individual assessment.)

To fix burnout, individuals and organizations must first identify the areas in which their mismatches lie, and then tailor solutions to improve the fit within each area. In Mark's case, his core problem is work overload. Workers in the nonprofit sector are distinctly vulnerable to work overload for two reasons. First, nonprofit organizations may often have fewer resources than organizations in other sectors, leaving workers with too little time and too few tools with which to handle their workload. Second, nonprofit employees have high expectations and are attempting to solve truly monumental problems. Their idealism can lead them to overextend themselves and take on too much.

Mark is also experiencing an imbalance in the area of values. Although workers in the nonprofit sector may not face the same ethical dilemmas that many workers in for-profit companies do, they often feel value conflicts of a different sort: between the loftiness of their ideals and the realities of their day-to-day work.

Burnout in a Crisis

How Katrina relief workers are faring

In the wake of Hurricane Katrina, Jan Wawrzyniak worked 15 hours a day for seven days straight, answering calls from people who were stranded or searching for relatives. Calls from New Orleans to 2-1-1, the nationwide human services referral phone line, were being forwarded to her United Way office in Monroe, La. She was suddenly catapulted from administrator to crisis operator, fielding hundreds of urgent requests for shelter, supplies, food, and funds. "I was sleeping three hours a night and eventually had a meltdown. I just couldn't stop crying," Wawrzyniak says.

She was suffering from the kind of burnout that many people working in intense and prolonged disaster situations face. For her and thousands of other relief workers in the Katrina effort, workload and control issues (see main article) packed the hardest punch. Too many problems to handle in too short a time – with inadequate resources and hand-tying bureaucracies – made things rough for professionals and volunteers alike.

"Before we expanded to a 50-person station, it was chaos," says Wawrzyniak of the Monroe outpost, which has fielded about 56,000 Katrina calls. "People telephoned in dire straits, and you'd feel frantic trying to get them what they needed – only to realize it wasn't working. One man said he was running out of diapers for his baby. He was considering breaking into the local Wal-Mart and leaving an IOU. It was heartbreaking."

Jack Slattery, a former Peace Corps volunteer, helped the Federal Emergency Management Agency (FEMA) set up a disaster recovery center in Bogalusa, La., and worked with hurricane victims filing for financial assistance. "FEMA told us it would be emotionally draining, and it was," says Slattery. "So many needs and so few resources." After a month of working 12-hour days, he was ready to go home.

"One of the things that made the job challenging was FEMA itself," Slattery says. "Orders came from above, military style, and there was an unwillingness to move the most urgent requests up the system." Slattery also says that FEMA's rules governing which Katrina victims received $2,000 aid grants seemed capricious, and frequently neglected the poorest and neediest. "It was frustrating to work in such an environment," he says.

Slattery personally coped by taking morning walks, waking up every day at 6 a.m. "It helped me release stress," he says. He also vented his emotions to his wife and other workers.

Wawrzyniak's 2-1-1 operation instituted rotating schedules so that everyone could take at least one day a week off. The center also made crisis counselors available to workers on every shift.

Such techniques are recommended by the American Psychological Association, which regularly provides mental health workers to the American Red Cross for disaster relief efforts. "The Red Cross approach used to be: Work until the job gets done," says Richard Heaps, a psychologist who helped organize counseling services for Katrina victims in September. "Giving workers periods of rest to recover their energies makes them better able to serve others," he says.

Or, as flight attendants say, put the mask on your own face before attempting to assist others.

–Marguerite Rigoglioso

Where to start? Hurricane relief workers find coping with disaster overwhelming without care for themselves.

PHOTOGRAPH BY NICHOLAS KAMM/GETTY IMAGES

An Organizational Approach to Healing Burnout

SEVERAL YEARS AGO, THE BUSINESS AND administrative services division of a large nonprofit institution was facing serious troubles. Its talented workforce had become demoralized and burned-out, and no wonder. The organization's management corps was minimally trained. Its far-flung departments had trouble communicating with each other. Its 17 departments had become 17 silos, rarely collaborating. There were almost as many organizational strategies as there were staff members. And to top it all off, the organization lacked important resources.

The division's management decided to use our organizational checkup survey to measure burnout across the six areas. All employees were given the opportunity to fill out this probing questionnaire, which was locally retitled the "Let's Hear It! Survey." Ninety percent of the 1,100 staff replied with gusto, adding reams of free-form comments.

Administering the survey, we observed many telling moments. In a particularly troubled wing of the organization, six supervisors refused to take the survey as long as their common manager was in the room. About 70 staff took the survey in one of five languages other than English. (Oral translation was provided in Spanish, Cantonese, Laotian, Vietnamese, and Tagalog.) These staff members, for whom English was a second (or third) language, showed remarkable enthusiasm for the survey – the first time ever that they had been invited to communicate in the workplace in their native language.

The survey results showed that the biggest problem areas were fairness and values. For instance, the staff felt that favoritism guided promotions, and that a special bonus program was not actually based on merit. Employees from every frontline unit were formed into committees, charged with examining the survey results for their unit and with developing initiatives for change. One committee, for example, worked to develop a distinguished service award that would be judged as a fair way to reward people who had made exceptional contributions to the organization's goals. A year later, a second survey showed that these changes had led to successful improvements in all six areas, but especially the targeted ones of fairness and values.

–Christina Maslach and Michael P. Leiter

This is what is going on with Mark, who often feels so bogged down in the details of organizing volunteers and coordinating actions that he loses sight of the larger goal of environmental preservation. His work no longer feels meaningful to him.

Mark also feels a lot of dissatisfaction in the area of rewards. No one goes into the nonprofit sector to get rich, but Mark expected to enjoy his activist activities more. He also expected more appreciation and praise from his colleagues and from the communities he serves.

In contrast, Susan's core problem is in the area of community.[7] In her work setting, she is excluded from her colleagues' circle of support, and she spends a lot of time feeling isolated and lonely. Being left out of the loop introduces a second mismatch for Susan, this time in the area of control. By the time an issue appears on a meeting's formal agenda, the matter has already been settled in the informal conversations in which Susan could not participate. As a result, Susan does not feel that she has an adequate say in how she does her work.

As time wears on, Susan has begun to suspect that her lack of community and control at work are due to a third area of mismatch: fairness. She wonders whether the male doctors in the ER are discriminating against her because she is a woman. Because of this hint of injustice, Susan feels not only anxious and uncertain about how best to do her job, but also angry and hostile toward her colleagues.

Two Paths to Engagement

There are two paths to banishing burnout: the individual path, and the organizational path. Both Mark and Susan took individual approaches; they first identified the mismatches leading to their burnout, and then enlisted their colleagues and organizations in addressing those mismatches.[8]

An organizational approach, in contrast, starts with management first identifying mismatches that are commonly shared, and then connecting with individuals to narrow these person-organization gaps.[9] The sidebar (left) describes how this organizational approach was used in a large organization. This strategy of working collaboratively on shared problems can be used in organizations of any size, even those nonprofits that are small and that have limited resources.

No matter the path to engagement, it is important to keep in mind that positive changes don't just happen. Instead, people must take action, and well-informed action, at that. Rather than assumptions and "best guesses" about what the problem is, the six-area diagnostic tool can help pinpoint it more accurately. Solutions that don't address the problem can be worse than no solutions at all.

For example, we recall attending a meeting of teachers for which the school superintendent had hired a motivational speaker to inspire them and help them deal with stress. As the speaker reeled off stories from his own days as an athletic coach, we watched the teachers sitting silently, their venom rising with each minute. They did not lack motivation. Decent pay, adequate supplies, parents' support, a manageable workload, yes. But not motivation. The superintendent's well-meaning attempt to nip burnout in the bud only nurtured it.

PHOTOGRAPH BY BRAD WILSON/GETTY IMAGES

"It's not just about working with the patients. It's also about taking on colleagues and relationships to make sure you're included and respected."

Lightening Mark's Load

Having identified workload as his main relationship problem with his work, Mark is finding ways to relax during strenuous times. He now takes regular breaks in which he gets away from the job, either physically (e.g., by jogging around the neighborhood) or mentally (e.g., by reading a book that has nothing to do with his activist interests). Even more effective for him are temporary changes in work, in which he "downshifts" to some less demanding task (e.g., taking care of routine paperwork, sweeping the floor) before returning to the more challenging jobs.

Another critical discovery for Mark is that he really didn't have to be the center of his activist universe. Instead of being the lone person who does everything, he is learning to delegate tasks, to train others to do what he did, and to get them to share the responsibility. "Now I don't struggle against the feeling of burnout," he says. "I'll say to myself: 'Oh, I'm burned out, I'll just sit here for a while. Let somebody else do it.' And you know what? Somebody else does."

Mark's new perspective on his place in his activist organization reflects the wisdom of an older colleague who told him: "When I was younger, I was convinced that I needed to drive myself every single minute. Now I feel that I can go to the sauna, and I'll still hate imperialism in an hour and a half. And that's helped me to stay an activist."

By addressing his workload problem, Mark has simultaneously improved the fit between him and his activist work on the dimension of value. To relieve stress, he took several long hikes in the wilderness, which renewed his feelings of awe at the beauty of nature – feelings that fueled his commitment to environmental activism in the first place. "I felt in love. It was a passion I hadn't felt in a long time. There was very little burnout. Instead there was a craving."

Building Susan's Community

After zeroing in on community as her primary area of self-work mismatch, Susan first took a few minutes at the start of her next shift to talk with Tom, one of the most approachable of the doctors. Tom told Susan that he was amazed that she could feel left out, and assured her that no one intended to exclude her. Susan didn't quite buy Tom's assurances, but nevertheless replied that she was pleased to hear this, because she certainly didn't want to go through the complicated, time-consuming, and awkward process of making a formal complaint. She was confident that before too long, the ER doctors' clique would know all about their conversation.

Susan took the second step toward narrowing the gap between her expectations and her work reality at the next meeting of the ER medical staff. She told the staff that she was feeling left out of important decisions, and requested that they include her in all discussions about clinical matters and hospital issues during her shift. There were a few furtive glances, but overall most people nodded and said, "Of course."

With Tom and a few other doctors, Susan has smoothly moved into relaxed conversations. She refers to her feelings of burnout only within the context of working on better ways of working together. With the other doctors, it has been more of an uphill battle, but is still an improvement over silence. Since Susan took her complaints to her colleagues, there have been a lot fewer surprises at medical staff meetings, making Susan feel like she has more say in her work environment. She also now realizes that the doctors' previous exclusive patterns were more a matter of thoughtlessness than a concerted campaign to exclude her – thereby assuaging her fears of sexism.

Feeling that she is part of a community, respected, and in control is giving Susan a renewed enthusiasm for her work. The end of the shift brings the same familiar pattern of aches and pains from the hours on her feet. But the dullness of feeling is now rare.

"Looking back now, I'm shocked to think of how close I was to losing my connection to the work that I love and that I do very well," she says. "It's not just about working with the

Quick Burnout Assessment

To give an idea of how we assess burnout, here are a few items from our book, *"Banishing Burnout: Six Strategies for Improving Your Relationship With Work."* Please note, however, that this is not a complete survey.

For each item, think about how your current work matches up with your personal preferences, work patterns, and aspirations.

	Just Right	Mismatch	Major Mismatch
Workload			
The amount of work to complete in a day			
The frequency of surprising, unexpected events			
Control			
My participation in decisions that affect my work			
The quality of leadership from upper management			
Reward			
Recognition for achievements from my supervisor			
Opportunities for bonuses or raises			
Community			
The frequency of supportive interactions at work			
The closeness of personal friendships at work			
Fairness			
Management's dedication to giving everyone equal consideration			
Clear and open procedures for allocating rewards and promotions			
Values			
The potential of my work to contribute to the larger community			
My confidence that the organization's mission is meaningful			

- If everything is a match, you have found an excellent setting for your work
- A few mismatches are not very surprising. People are usually willing and able to tolerate them
- A lot of mismatches, and especially major mismatches in areas that are very important to you, are signs of a potentially intolerable situation

A good understanding of burnout is essential to keeping the flame of compassion and dedication burning brightly.

PHOTOGRAPH BY TOM COLLICOTT

patients. It's taking on colleagues and relationships to make sure you're included and respected."

By confronting the situation in an informed and focused way, Susan has been able to repair the relationship between herself and her work. An important principle in Susan's situation is that unfair treatment is difficult to sustain after it has been brought into the open. There were no defensible grounds for excluding Susan from professional discussions at work. But the situation persisted until Susan called her colleagues on their actions.

Shining On

Mark and Susan have had different experiences of burnout, reflecting the unique qualities of their work settings. Each situation involved a different area of mismatch, and each called for distinct solutions. Note that neither attempted to address all of their mismatches at once. Rather, each first identified and addressed his or her core area of concern.

Both had also begun to feel the personal costs of burnout, which include poorer health and strained private lives. But at least as important, Mark's and Susan's organizations had also begun to suffer. When employees shift to minimum performance, minimum standards of working, and minimum production quality, rather than performing at their best, they make more errors, become less thorough, and have less creativity for solving problems. They are also less committed to the organization and less willing to go the extra mile to make a real difference.

Burnout is not a problem of individuals but of the social environment in which they work. Workplaces shape how people interact with one another and how they carry out their jobs. When the workplace does not recognize the human side of work, and there are major mismatches between the nature of the job and the nature of people, there will be a greater risk of burnout. A good understanding of burnout, its dynamics, and what to do to overcome it is therefore an essential part of staying true to the pursuit of a noble cause, and keeping the flame of compassion and dedication burning brightly. □

---

1 "Mark" and "Susan" are pseudonyms.
2 For our review of the psychological literature on burnout, see Maslach, C., Schaufeli, W.B., & Leiter, M.P. "Job Burnout," in *Annual Review of Psychology* 52, eds. S.T. Fiske, D.L. Schacter, & C. Zahn-Waxler (2001): 397-422.
3 Maslach, C. & Leiter, M.P. *The Truth About Burnout* (San Francisco: Jossey-Bass, 1997).
4 Leiter, M.P. & Maslach, C. "Areas of Worklife: A Structured Approach to Organizational Predictors of Job Burnout," in *Research in Occupational Stress and Well-Being* 3, eds. P.L. Perrewe & D.C. Ganster (Oxford: Elsevier, 2004): 91-134.
5 Leiter, M.P. & Maslach, C. *Preventing Burnout and Building Engagement: A Complete Program for Organizational Renewal* (San Francisco: Jossey-Bass, 2000).
6 Leiter, M.P. & Maslach, C. *Banishing Burnout: Six Strategies for Improving Your Relationship With Work* (San Francisco: Jossey-Bass, 2005).
7 See also De Jonge, J. & Kompier, M.A.J. "A Critical Examination of the Demand-Control-Support Model From a Work Psychological Perspective," *International Journal of Stress Management* 4 (1997): 235-258.
8 Leiter & Maslach, *Banishing Burnout: Six Strategies for Improving Your Relationship With Work*.
9 Leiter & Maslach, *Preventing Burnout and Building Engagement: A Complete Program for Organizational Renewal*.

TALK BACK: What are your reactions to this article? Join our online forum at **www.ssireview.com/forum.**

The Reflective Process —
Analysing & Learning from Experience

1. Gather the Information

- Describe the incident
- Explain the context
- Take any relevant clarifying statements from others involved

2. The Reflection

- What was I trying to achieve?
- What were the consequences of my action for the patient, for my colleagues, for me?
- What do I feel about it?
- What has been the effect on my colleagues?
- What factors/previous knowledge may have influenced me?
- What alternative action could I have taken?

3. The Learning Process

- How do I feel now?
- Could I have acted differently?
- What have I learnt?
- How will that influence my future practice?
- What has the incident taught me about my values and/or my belief system?
- What ethical principles were involved?

Once you have completed the process, it would be valuable to evaluate it again, with a colleague or with a professional mentor to clarify the main issues, the learning involved and the impact on your practice.

CHIRS WHITEHEAD
Professional Development Co-ordinator

February 1994

(Taken from “Centre for Health Education” info RD+E(H) April 02)

What is Reflective Supervision and its value within domestic violence services and programs?

Reflective Supervision (RS) is:	…because in our work, we:
Reflective. RS allows staff to take a step back from the work and examine it differently.	Work at a fast pace and respond to crises
Collaborative. RS is a time for supervisors and supervisees to consider the work together, share ideas, and think about possible next steps.	Might feel isolated and like you are the only one that survivors and their families can depend on
Regular. RS is a predictable time when staff and supervisors can meet to consider the work.	Never know what to expect
Relationship-based. RS offers a secure, consistent relationship in which staff can experience the trust, support, and respect they offer the families they serve.	Develop relationships with survivors and their families that support individual strengths, safety and foster resilience
Focused on professional growth. RS supports staff – and supervisors! – in building skills important to their individual work.	Support survivors and their families to strengthen their relationships and enhance coping skills
Strengths-based. RS helps staff identify their unique strengths and supports staff in applying their skills to the challenges of the work.	Identify and build on the strengths of survivors and their families as they heal from the traumatic effects of experiencing DV
Safe. RS provides a secure environment where staff can discuss the strong feelings that are evoked in them, the real challenges of their work and their own vulnerabilities in a way that supports growth.	Build a trauma-informed atmosphere of safety, mutual trust and respect.
Individualized. RS is based in learning about each unique staff member and what is most helpful to them in their work.	Individualize your services to each survivor and family in the context of their culture and community
Characterized by active listening. Reflective supervisors listen intently to staff, paying attention to spoken language and unspoken cues.	Bear witness to their experiences and feelings, actively "listening" to what they tell you with their words, their voices and their body language.

Adapted by Expanded Training & Consultation Cadre (Chicago) NCDVTMH (2013) from the Early Head Start National Resource Center
http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc