CATCH UP WITH CAM

FALL 2025

www.ChildrensAllianceMT.org

"It is an honor to support the work you do!"

Children's Alliance OF MONTANA

Uniting Children's Advocacy Centers

One Voice, One Child, One Big Difference

Welcome to football season, hunting season and pumpkin everything season.

Here are CAM, we are grateful to all of you, the first responders on the front lines protecting children, and keeping communities safe. And for you we are humbled by your hard work and dedication.

I want to share some information on the peer review/peer support opportunities we have for many of you.

Medical Professionals

A. **Online expert, anonymous peer review** by Child Abuse Pediatric Sub board Specialists through the Midwest Regional CAC – **mycasereview.** CAM provides the annual subscription costs for this for medical providers working with MDTs and CACs.

B, **Monthly Medical Consultation Calls** with Dr. Kathi Wells, Dr. Nichole Wallace and their expert team at the Kemp Center in Denver.

Forensic Interviewers

A. **MCFIC = Montana Child Forensic Interview Collaboration.** Monthly calls with FI's across the state lead byh Paula Samms, Director, Lewis and Clark County CAC. Paula brings her vast knowledge and expertise along with new research and practices to the group for discussion. This forum is also a great place for interviewers to share experiences and expertise.

B. **Statewide FI Peer Review** – Paula Samms facilitates groups of 3 to 4 professionals across the state who would like to participate and have their interviews peer reviewed. Reminder, the NCA Standards require that each FI participate in 2 peer reviews per year. Click on the flyer on our website to register.

Mental Health Professionals

Enjoy monthly mini- TF-CBT trainings and peer consultation with TF-CBT Master Trainer, Dr. Amy Hoch, Dr. Hoch has been training professionals in Montana in TF-CBT since 2009.

HOW DO YOU ACCESS THESE RESOURCES? I'm so glad you asked. Please email any of the CAM staff and we can connect you or visit our website for more information.

Thank you again for all you do. Please don't hesitate to reach out if there is any way we can further support you. Brenda George

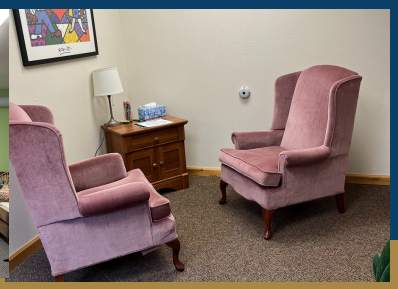
CAC SPOTLIGHT

Flathead County CAC and Sanders County FI Room

Flathead County CAC Family Waiting Area

Flathead County CAC Interview Room

Sanders County Family Waiting Area



Sanders County Interview Room

The Flathead County Child Advocacy Center in Kalispell, allows the capability for centralized services. Children receive forensic interviews and forensic medical exams at the CAC in a child friendly environment. The CAC utilizes a Multidisciplinary Team to provide comprehensive services to victims of child abuse. The Flathead CAC is a government based center. The Flathead County Sheriff's Office serves as the umbrella agency providing administrative support for the center.

The Sanders County Coalition for Families (SCCFF) was established in 1993 to address the critical needs off individuals and families impacted by violence and abuse. Most recently, SCCFF has convened a Multidisciplinary Team. This collaborative initiative brings together law enforcement, prosecution, victim advocacy, child protection, healthcare and mental health services to strengthen community response to these victims and their families.

WELCOME 4 NEW TEAMS!
LIBERTY, MINERAL, SANDERS,
ROSEBUD/TREASURE COUNTIES

We are excited to welcome 5 new counties that have established Multidisciplinary Teams.
Liberty county has been up and running since April and have remodeled space in the County Attorney's Office for a forensic interview room.
Mineral county has held two meetings and is looking for space to set up a forensic interview room.
Sanders county has had 3 meetings, has completed their interagency agreement and are working on protocols. The team attended MDT training.
Rosebud and Treasure counties have a collaborative, multi-county MDT. They have been meeting since February and sent an officer to the Montana Forensic Interview Training (MFIT) in June.
Congratulations to all these counties for putting in the hard work to better serve the victims and their families of these crimes.

NCA SHARED EXPERIENCES. STRONGER PRACTICES.
ENGAGE

Could your Prosecutors benefit from FREE - Child Abuse Cases - Specialty...

zeroabuseproject.org

Fall 2025 Virtual Prosecutor Institute Series
We're excited to announce the Fall 2025 Virtual Prosecutor Institute series presented by the Zero Abuse Project Senior Attorneys. All sessions will be conducted via Zoom and offered twice on each presentation day to accommodate different schedules.**... more**

Questions? Contact CAM at
PO Box 666
Billings, MT 59103
director@childrensalliancemt.org
406.672.2136

THERE IS STILL TIME TO REGISTER

This ADVANCED FORENSIC INTERVIEW TRAINING is sponsored by the Children's Alliance of Montana

October 21st 9:00 A.M. - 5:00 P.M.
FORENSIC INTERVIEWS OF PRESCHOOLERS AND CHILDREN WITH SPECIAL NEEDS

October 22nd 8:00 A.M. - 3:00 P.M.
STATEWIDE FORENSIC INTERVIEW PEER REVIEW

WHO SHOULD ATTEND:
- Forensic Interviewers regularly conducting forensic interviews.
- Multidisciplinary Team Members

FAIRMONT HOT SPRINGS RESORT

-JOIN US IN PERSON OR VIRTUALLY FOR ONLY DAY 1-

-Registration Deadline- SEPTEMBER 19TH

* No Registration Fee*
Must Register to Attend

DAY 1 - Forensic Interviews of Preschoolers and Children with Special Needs

PRESENTER: WENDY A. DUTTON MA, PhD, LPC - Dr. Dutton has been a forensic interviewer for the past 33 years, at St. Joseph's Hospital and Phoenix Children's Hospital in Phoenix. She has conducted more than 12,000 forensic interviews, and she has testified over 750 times as an expert witness in child abuse cases.

TRAINING DESCRIPTION AND LEARNING OBJECTIVES:
Investigating allegations of abuse involving pre-school-aged children and children with special needs can be challenging. Investigators must balance the need to protect children from further abuse and avoid misleading these vulnerable witnesses into making false reports.
- The difficulties and pitfalls of interviewing children ages 3 to 6.
- Best practice in forensic interviews of preschoolers and children with special needs.
- Preparation for interviewing children who have hearing impairments, language delays and intellectual disabilities.
- Case presentations and discussion of forensic interviews of preschoolers and children with disabilities.

POST and CLE Credit APPROVAL PENDING

-CLICK HERE- REGISTER NOW

DAY 2 - Statewide Forensic Interview Peer Review

Participants will be divided into groups. Each group will have a facilitator. The groups will peer review each other's forensic interviews. Participants will need to bring an interview to review. You will not be able to participant if you do not bring an interview to review.

TRAINING DESCRIPTION:
- Forensic interview peer review is crucial to maintaining the skills necessary to improve practice to conduct age-appropriate and legally-defensible forensic interviews with children.
- To maintain good practice, the National Children's Alliance Standards require Peer Review 2 times per year with peers outside of your multidisciplinary team.

Limited Lodging Scholarships Available

EVERYONE MUST MAKE THEIR OWN ROOM RESERVATIONS

If awarded a lodging scholarship, your reservation will be transferred to the CAM direct bill.

When making reservations reference the Children's Alliance of Montana Block of Rooms.

See Below for Additional Lodging Scholarship Information

LODGING SCHOLARSHIP INFORMATION Fairmont Hot Springs Resort Phone Number: (406) 797-3241
- There are a limited number of lodging scholarships available.
- Email Dani Peterson- training@childrensalliancemt.org if you would like to apply for a lodging scholarship.
- Priority for receiving a lodging scholarship will be given to Forensic Interviewers and members of the

SAVE THE DATE

Children's Alliance OF MONTANA
Uniting Children's Advocacy Centers
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10TH ANNUAL MONTANA CHILDREN'S JUSTICE CONFERENCE

MARCH 10-12, 2026

A CROSS-DISCIPLINARY CONFERENCE FOR MULTIDISCIPLINARY TEAMS

- March 10th 1:00 pm - 5:00 pm
- March 11th 8:30 am - 5:00 pm
- March 12th 8:00 am - 12:00 pm

BILLINGS, MT
DOUBLETREE BY HILTON - BILLINGS

CONFERENCE LINE UP COMING SOON

AGENDA AND LODGING INFORMATION -COMING SOON-

REGISTRATION OPEN - DECEMBER 2025 -

QUESTIONS:
CONTACT DANI PETERSON
TRAINING@CHILDRENSALLIANCEMT.ORG

THIS TRAINING EVENT IS SPONSORED BY THE CHILDREN'S ALLIANCE OF MONTANA AND THE MCSART PROGRAM OF THE MONTANA DEPARTMENT OF JUSTICE

KEEP MOVING FORWARD

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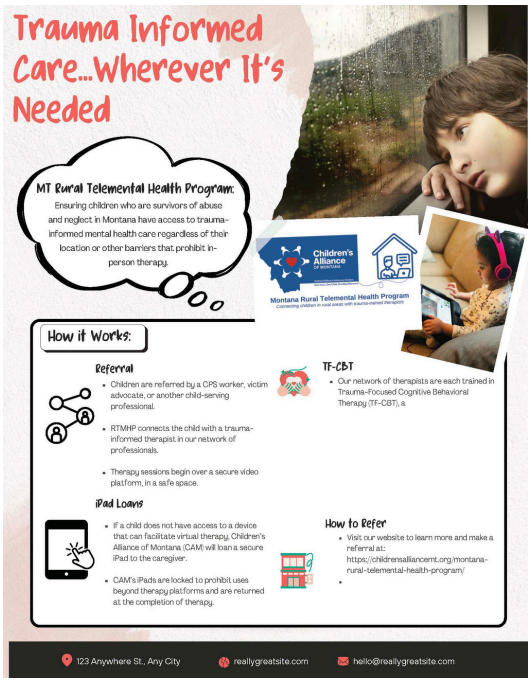
Montana Rural Telemental Health Program

Connecting children in rural areas with trauma-trained therapists

Brenda George, Executive Director
Danielle Peterson, Training Coordinator
Jacole Douglas, Rural Telemental Health Program Coordinator
Joy Lucero, Project Coordinator



Resources

Contact us for electronic copies:
jlucero@childrensalliancemt.org

Vicarious Trauma v Secondary Trauma

National Children's Alliance
The Force Behind Children's Advocacy Centers

From the CEO's Desk

July 14, 2025

Vicarious Trauma vs. Secondary Traumatic Stress: What's the Difference?

Good morning and welcome back to Monday. I hope this finds everyone continuing to stay safe and healthy. This morning, I want to focus for a moment on the issues of secondary traumatic stress (STS) and vicarious traumatization (VT). In our world, we tend to use the two terms interchangeably, but a recent study published in the journal *Psychological Trauma: Theory, Research, Practice, and Policy* analyzed both the differences between them and the overlap.

The study is entitled "*Untangling Secondary Traumatic Stress and Vicarious Traumatization: One Construct or Two?*" – and while it is a technical piece, mostly directed to other researchers in the field, it has some important points for our field, and for those in our field who are most at risk for STS and VT. As a starting proposition, the researchers note that "[t]here is an ethical responsibility for helping professionals to be made aware of the potential risks of indirect exposure to their mental health, the importance of caring for themselves as a part of doing the work, and for organizations to become more informed." Id., p. 621.

The researchers begin by defining their terms: "STS can be defined as a reaction following indirect exposure to trauma experiences of another, resulting in symptoms that align with those of PTSD but for which full PTSD symptom criteria do not have to be met..... Symptoms of STS occur on a continuum ranging from an absence of STS symptoms to symptoms that meet the full criteria for PTSD." Id., p. 622. VT, on the other hand, is "the negative cumulative changes in a person's beliefs about self, others, and the world around them and their perceptions of trust and safety following indirect exposure to the traumatic experiences of others." Id. Over time, "indirect exposure to traumatic details can disrupt cognitive schemas related to safety and trust, perceptions of self (e.g., "I cannot help this client," "I am not OK"), and assumptions of others (e.g., "Others cannot be trusted," "The world is dangerous"), leading to affective distress." Id.

Another way to conceptualize the difference between the two conditions is that "STS is understood as a more acute response to indirect exposure" resulting in traumatic stress-related symptoms, whereas VT is understood as a "cognitive phenomenon" that results in a negative shift in how the self and the world are perceived.

At the same time, of course, there is overlap between the two concepts, particularly in terms of risk factors – for both phenomena, "personal trauma histories and higher doses of indirect exposure" increase risk. Notably, "working within child welfare has been found to be associated with greater total STS symptoms, compared to other occupations...." Id.

To conduct the study, the researchers recruited participants to participate in a survey using listservs of known networks and agencies in the United States that work with this population. From an initial pool of 646 professionals working with those exposed to trauma, the final pool was comprised of 613 professionals from all 50 states and Puerto Rico. The sampling was diverse, and the ages of the participants ranged from 35 to 54.

The first thing to note about the results is that the "rates of indirect exposure in this sample were notably high (approximately 67% of an average workday exposed to the trauma details of others)." Id., p. 625. Indeed, the rates found here are consistent with a previous study "of military personnel postdeployment...." Id. Interestingly, in the current study, having a personal history of trauma "was associated with less total, intrusion, and arousal STS symptoms and was not associated with VT symptoms." Id., p. 626. In other words, being exposed to the trauma of others was generally not a trigger for those with a personal history of trauma. Likewise, and similarly somewhat surprisingly, the researchers found that those with longer professional histories of exposure to trauma had lower STS and VT symptoms than those with less professional experience. This suggests that the symptoms of STS and VT "may not happen over the course of many years, as having less experience was associated with more severe VT symptoms and STS symptoms of negative alterations in cognition and mood." Id. Additionally, the researchers found that "dose exposure" – that is, daily indirect exposure to trauma – "does not differentiate STS and VT symptoms, and in fact, was similarly associated with each construct's symptom domains." Id. Finally, the researchers found that "those in child protection/advocacy, in the current study, had higher total PMBS [Posttraumatic Maladaptive Belief Symptoms] and Threat of Harm scores than those in occupations of healthcare and had greater total STS, intrusion, and arousal symptoms than those in legal settings." Id., pp. 626-627.

The findings suggest that there is a "high degree of overlap and similarity in STS and VT" with the greatest overlap in the following symptoms: "difficulties concentrating, feeling easily annoyed, expecting bad things to happen, being upset by reminders, and little interest in being around others." Id., p. 627. Despite the considerable degree of overlap, however, the researchers still advocate for the two to remain separate, but related, phenomena. Not all the symptoms of STS cover the symptoms of VT, and vice versa. So, for example, "an individual may have elevated VT but not STS symptoms or elevated STS but not VT symptoms." Id., p. 628.

In the final analysis, the researchers emphasize the importance of screening for both types of symptoms. They recommend that organizational leadership pay "special attention" to all the symptoms, but especially to those indicating avoidance (i.e., avoiding internal and external reminders), hyperarousal (i.e., engaging in reckless behavior), and changes in mood and cognition (i.e., blaming others for clients' trauma). Id., p. 627. They also note that it is critical for "interventions and assessment efforts to target early career professionals and those exposed to higher levels of indirect trauma." Id., p. 628.

These findings underscore what we already know about the impact of STS and VT, particularly on our colleagues and staff members. But they also underscore the importance of extending this understanding and support to our MDT members. The researchers found that the scores of those in the field of child protection/advocacy were comparable to those working in behavioral health, sex-trafficking-specific organizations, and education – in other words, our agency partners. The researchers also found that "social support buffers against both phenomena [that is, STS and VT]." Id. But if professionals suffering from either STS or VT respond by avoiding being around others, then we cannot provide that crucial social support for one another. This emphasizes the reasoning behind Essential Component I of Standard 9, Organizational Capacity of NCA's *National Standards of Accreditation for Children's Advocacy Centers*. This component requires that "[t]he CAC provides training opportunities and resources on vicarious trauma and building resiliency to all MDT members." We know that "the health of the MDT as a whole directly impacts service delivery to children and families. Therefore, attention to this issue is important for