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Trauma-Informed Practice

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Ken Kraybill, MSW
C4 Innovations
kkraybill@c4innovates.com

Trauma-Informed Care Basics

How can you provide optimal care for people who have experienced trauma? In this article, we share best practices for trauma-informed care. These include understanding trauma and its effects, creating safe physical and emotional space, supporting control and choice, and integrating trauma-informed care across service systems.

Some people experience very few traumatic events in their lives. Others experience chronic traumatic stress that can potentially have a major impact on how people understand themselves, the world, and others. People who have experienced multiple traumas do not relate to the world in the same way as those who have not. They require services and responses that are uniquely sensitive to their needs.

What makes an experience traumatic?

- The experience involves a threat to one's physical or emotional well-being.
- It is overwhelming.
- It results in intense feelings of fear and lack of control.
- It leaves people feeling helpless.
- It changes the way a person understands themselves, the world and others.

Trauma-awareness

We know people can and do recover from trauma, and we want to provide services and environments that support healing. To be a "trauma-informed" provider is to root your care in an understanding of the impact of trauma and the specific needs of trauma survivors. We want to avoid causing additional harm to those we serve.

What does this mean in practical terms? How is this different than business as usual? Here are some concrete practices of trauma-informed care.

Understanding trauma and its impact

Understanding traumatic stress and its impact is essential. Trauma survivors, particularly those who have experienced early childhood trauma/developmental trauma, often develop a set of survival skills that help them to manage past trauma. These survival strategies (like substance misuse, withdrawal, aggression, self-harm, etc.) make sense given what people have experienced. But they can be confusing and frustrating to others and often get in the way of current goals.

Without an understanding of trauma, providers may view those they serve in negative ways. Providers might describe behaviors as "manipulative," "oppositional," or "unmotivated." Yet these behaviors may be better understood as strategies to manage overwhelming feelings and situations. Trauma-informed training can help providers understand these responses and offer trauma-sensitive care.

Promoting physical and emotional safety

Traumatic experiences often leave people feeling unsafe and distrustful of others. Creating a sense of physical and emotional safety is an essential first step to building effective helping relationships. Safe physical environments may include:

- Well-lit spaces
- Security systems; an ability for individuals to lock doors and windows

- Visible posting rights and other important information
- Culturally familiar signs and decorations
- Child-friendly spaces that include objects for self-soothing

Practices that help to create a safe emotional environment include:

- Providing consistent, respectful responses to individuals across the agency
- Asking people what does and does not work for them
- Being clear about how personal information is used
- Permitting people to engage in their own cultural and spiritual rituals
- Provide group activities that promote agency and community (e.g. movement, exercise, yoga, music, dancing, writing, visual arts)

Supporting control and choice

Situations that leave people feeling helpless, fearful, or out of control remind them of their past traumatic experiences and leave them feeling re-traumatized. Ways to help individuals regain a sense of control over their daily lives include:

- Teach emotional self-regulation skills such as altering breathing and heart rate
- Keep individuals well informed about all aspects of their care
- Provide opportunities for input into decisions about how a program is run
- Give people control over their own spaces and physical belongings
- Collaborate in setting service goals
- Assist in ways that are respectful of and specific to cultural backgrounds
- Maintain an overall awareness of and respect for basic human rights and freedoms

Integrating care across service systems

Becoming trauma-informed means adopting a holistic view of care and recognizing the connections between housing, employment, mental and physical health, substance abuse, and trauma histories. Providing trauma-informed care means working with community partners in housing, education, child welfare, early intervention, and mental health. Partnerships enhance communication among providers and help minimize clients' experiences of conflicting goals and requirements, duplicated efforts, and or of feeling overwhelmed by systems of care. It helps build relationships and resources to provide the best quality of care possible.

Becoming trauma-informed means a transformation in the way that providers meet the needs of those they serve. The ideas above are only a beginning. Change happens as organizations and providers take these ideas, as well as their own, and use them to evaluate and adapt their approaches to care.

Adapted from *Trauma-Informed Care 101,* Homelessness Resource Center for Social Innovation
http://homeless.samhsa.gov/Resource/View.aspx?id=46857&g=ComResPosts&t=423

Understanding Trauma-Informed Care: What Does It Look Like ?

Trauma-Informed care represents a major shift in paradigm and practice. It has been defined as a system that realizes the widespread impact of trauma and adverse events, and seeks to actively resist re-traumatization of our clients by changing procedures and practices. Despite the recent calls for trauma-informed care across service sectors, providers continue to ask, "What does it look like?" In my recent book, Through a Trauma Lens: Transforming Health and Behavioral Health Systems, I share my first-hand experience and the experiences of a number of organizations that have successfully implemented trauma-informed practice.

Core components of a trauma-informed organization include:

1. A safe and welcoming environment - clients who have been traumatized have an exquisite sensitivity to cues of threat; they are hypervigilant and searching for indications that someone is going to hurt them. Safety has 3 levels: physical, psychological, and cultural. Physical safety includes establishment of a safe environment. It is also important to provide safety for all staff and to ensure that the organization does not repeat adverse/abusive environments.

2. Cultural Safety - This concept offers us one more step to enhance our understanding of the way culture affects our practice. A key principle is the need to recognize that both contemporary and historical inequities affect all our interactions. An essential feature of cultural safety is that the client defines whether or not the practice/provider are culturally safe. We ask the client "Do you feel safe here, with me?"

3. Voice & Choice for Clients - Since trauma imposes loss of control, a trauma-informed approach will focus upon the client having control over aspects of the treatment and being a full partner in treatment decisions (empowerment).

4. Screening - It is recommended that trauma screening be implemented, and I advocate for a trauma-informed introduction: "I'm going to ask you some sensitive questions. If you don't want to answer, please tell me that." If the client states that he/she prefers not to answer a question, that alerts us that the client probably does have a problem with abuse and we should make a note of that. The ACE Questionnaire is one of the screening tools recommended.

5. Trauma-Specific Interventions should be available (either on site or through referral) - These interventions (e.g., Seeking Safety, Trauma-CBT) directly address the effects of trauma on the client's life and facilitate recovery by helping the client to understand the connections between the trauma and subsequent feelings and behavior, and teaching coping skills to help him/her regain a sense of control, build more positive and safe relationships, and adopt safer behaviors.

6. Peer Supports - The peer "who has been there" can empathized with a client's fears, as well as educate the client on what to expect in treatment and other services and how to

navigate the system. Other unique contributions include: the installation of hope and a relationship characterized by trust. acceptance, and cultural understanding.

7. Training of Staff - Trauma training should be multi-leveled; Every staff member receives basic training on trauma (this includes receptionists, security staff, maintenance staff, etc.). For the staff who will be implementing trauma-specific interventions, there is training on the interventions. There also needs to be training on trauma-informed supervision for supervisors.

8. Self-Care for Staff - Another important component is an awareness that providers may also have experienced trauma. Even if they have not, working with clients who have survived traumatic experiences and listening to their stories can take an emotional toll and lead to secondary trauma. Organizations need to implement a number of actions to help staff including supervision, staff debriefing groups, a calm room where staff can meet or a single staff member can relax or meditate. It is also important that caseloads are held to a reasonable level.

Vivian Brown 9/23/2018 https://www.acesconnection.com/blog/understanding-trauma-informed-care-what-does-it-look-like

Types of Trauma and Violence

Traumatic events impact individuals, families, and communities. They can include:

Sexual Abuse or Assault Sexual abuse or assault includes unwanted or coercive sexual contact, exposure to age-inappropriate sexual material or environments, and sexual exploitation. The Department of Justice's (DOJ) https://www.justice.gov/ovw defines sexual assault as "any type of sexual contact or behavior that occurs without the explicit consent of the recipient."

Physical Abuse or Assault Physical abuse or assault is defined as the actual or attempted infliction of physical pain (with or without the use of an object or weapon), including the use of severe corporeal punishment. Federal law defines child abuse as any act, or failure to act, which results in death, serious physical or emotional harm, sexual abuse, or exploitation of a child.

Emotional Abuse or Psychological Maltreatment Emotional abuse and psychological maltreatment are considered acts of commission (other than physical or sexual abuse) against an individual. These kinds of acts, which include verbal abuse, emotional abuse, and excessive demands or expectations, may cause an individual to experience conduct, cognitive, affective, or other mental disturbances. These acts also include acts of omission against a minor such as emotional neglect or intentional social deprivation, which cause, or could cause, a child to experience conduct, cognitive, affective, or other mental disturbances.

Neglect Neglect is the most common form of abuse reported to child welfare authorities. However, it does not occur only with children. It can also happen when a primary caregiver fails to give an adult the care they need, even though the caregiver can afford to, or has the help to do so. Neglect also includes the failure to provide an individual with basic needs such as food, clothing, or shelter. It can also mean not providing medical or mental health treatment or prescribed medicines. Neglect also includes exposing someone to dangerous environments, abandoning a person, or expelling them from home.

Serious Accident, Illness, or Medical Procedure Trauma can occur when a person experiences an unintentional injury or accident, a physical illness, or medical procedures that are extremely painful and/or life threatening.

Victim or Witness to Domestic Violence According to DOJ's Office of Violence Against Women, domestic violence is defined as: "a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone." Domestic violence includes violence and abuse by current or former intimate partners, parents, children, siblings, and other relatives.

Victim or Witness to Community Violence Extreme violence in the community, including exposure to gang-related violence, interracial violence, police and citizen altercations, and other forms of destructive individual and group violence is a recognized form of trauma.

Historical Trauma Historical trauma is a form of trauma that impacts entire communities. It refers to the cumulative emotional and psychological wounding, as a result of group traumatic experiences, that is transmitted across generations within a community. Unresolved grief and anger often accompany this trauma and contribute to physical and behavioral health disorders. This type

of trauma is often associated with racial and ethnic population groups in the United States who have suffered major intergenerational losses and assaults on their culture and well-being.

School Violence School violence is described as violence that occurs in a school setting and includes, but is not limited to, school shootings, bullying, interpersonal violence among classmates, and student suicide. Youth violence is a serious problem that can have lasting harmful effects on victims and their families, friends, and communities

Bullying Bullying is unwanted, aggressive behavior among school-aged children that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Both kids who are bullied and who bully others may experience serious, lasting problems. Trauma can be a consequence of bullying, which can lead to mental health issues, substance use, and suicide, particularly if there is a prior history of depression or delinquency.

Natural or Manmade Disasters Trauma can result from a major accident or disaster that is an unintentional result of a manmade or natural event. Disasters can occur naturally (such as tornadoes, hurricanes, earthquakes, floods, wildfires, mudslides, or drought) or be human-caused (such as mass shootings, chemical spills, or terrorist attacks).

Forced Displacement Forced displacement is a traumatic event that occurs when people face political persecution and are forced to relocate to a new home (as an immigrant or through political asylum) or become a refugee.

War, Terrorism, or Political Violence Exposure to acts of war-, terrorism-, or political-related violence such as bombing, shooting, and looting can cause trauma in an individual.

Military Trauma Military trauma refers to both the impact of deployment and trauma-related stress on people who are deployed and their families. Significant numbers of returning service men and women experience mental and/or substance use disorders associated with military trauma and/or military sexual trauma.

Victim or Witness to Extreme Personal or Interpersonal Violence. This type of trauma includes extreme violence by or between individuals including exposure to homicide, suicide, and other extreme events.

Traumatic Grief or Separation Traumatic grief and/or separation may include the death of a parent, primary caretaker, or sibling; abrupt and/or unexpected, accidental, or premature death or homicide of a close friend, family member, or other close relative; abrupt, unexplained and/or indefinite separation from a parent, primary caretaker, or sibling due to uncontrollable circumstances.

System-Induced Trauma and Re-traumatization Many systems that are designed to help individuals and families can actually cause trauma. For example, in child welfare systems, abrupt removal from the home, foster placement, sibling separation, or multiple placements in a short amount of time can retraumatize children. In mental health systems, the use of seclusion and restraint on previously traumatized individuals can revive memories of trauma. Further, invasive medical procedures on a trauma victim can re-induce traumatic reactions.

Adapted from: https://www.samhsa.gov/trauma-violence/types

Complex Post Traumatic Stress Disorder (C-PTSD)

Complex Post Traumatic Stress Disorder (C-PTSD) is a condition that results from chronic or long-term exposure to trauma over which a person has little or no control and from which there is little or no hope of escape, such as in cases of:

- Childhood/domestic emotional, physical or sexual abuse
- Repeated violations of personal boundaries
- Long-term objectification
- Exposure to gaslighting/mental abuse and false accusations
- Long-term exposure to inconsistent, push-pull, splitting or alternating raging and hoovering behaviors
- Long-term taking care of mentally ill or chronically sick family members
- Entrapment, kidnapping
- Slavery or enforced labor
- Long term imprisonment and torture
- Long term exposure to crisis conditions

When people have been trapped in a situation over which they had little or no control at the beginning, middle or end, they can carry an intense sense of dread even after that situation is removed. This is because they know how bad things can possibly be. And they know that it could possibly happen again. And they know that if it ever does happen again, it might be worse than before.

The degree of C-PTSD trauma cannot be defined purely in terms of the trauma that a person has experienced. It is important to understand that each person is different and has a different tolerance level to trauma. Therefore, what one person may be able to shake off, another person may not. Therefore, more or less exposure to trauma does not necessarily make the C-PTSD any more or less severe.

People experiencing symptoms of C-PTSD may "stuff" or suppress their emotional reaction to traumatic events without resolution either because they believe each event by itself doesn't seem like such a big deal or because they see no satisfactory resolution opportunity available to them. This suppression of "emotional baggage" can continue for a long time either until a "last straw" event occurs, or a safer emotional environment emerges, and the damn begins to break.

The "Complex" in Complex Post Traumatic Disorder describes how one layer after another of trauma can interact with one another. Sometimes, it is mistakenly assumed that the most recent traumatic event in a person's life is the one that brought them to their knees. However, just addressing that single most-recent event may possibly be an invalidating experience for the C-PTSD sufferer. Therefore, it is important to recognize that those who suffer from C-PTSD may be experiencing feelings from all their traumatic exposure, even as they try to address the most recent traumatic event.

This is what differentiates C-PTSD from the classic PTSD diagnosis – which typically describes an emotional response to a single or to a discrete number of traumatic events.

Difference between C-PTSD & PTSD

Although similar, Complex Post Traumatic Stress Disorder (C-PTSD) differs from the more commonly understood and diagnosed condition Post Traumatic Stress Disorder (PTSD) in causes and symptoms. C-PTSD results more from chronic repetitive stress from which there is little chance of escape. PTSD can result from single events, or short-term exposure to extreme stress or trauma. Therefore, a soldier returning from intense battle may be likely to show PTSD symptoms, but a kidnapped prisoner of war who was held for several years may show additional symptoms of C-

PTSD. Similarly, a child who witnesses a friend's death in an accident may exhibit some symptoms of PTSD but a child who grows up in an abusive home may exhibit the additional C-PTSD characteristics shown below.

C-PTSD - What it feels like

People experiencing C-PTSD may feel uncentered and shaky, as if they are likely to have an embarrassing emotional breakdown or burst into tears at any moment. They may feel unloved, or that nothing they can accomplish is ever going to be "good enough" for others.

Sometimes people living with C-PTSD may feel compelled to get away from others and be by themselves, so that no-one will witness what may come next. They may feel afraid to form close friendships to prevent possible loss should another catastrophe strike.

People may feel that everything is just about to go "out the window" and that they will not be able to handle even the simplest task. They may be too distracted by what is going on at home to focus on being successful at school or in the workplace.

C-PTSD characteristics

How it can manifest in a person over time:

- ***Rage turned inward*** – eating disorders, depression, alcohol/other substance misuse, truancy, dropping out, promiscuity, co-dependence doormat syndrome (choosing poor partners, trying to please someone who can never be pleased, trying to resolve the primal relationship)
- ***Rage turned outward*** – theft, destruction of property, violence, becoming a control freak
- ***Other –*** learned hyper vigilance, clouded perception or blinders about others (especially romantic partners), seeks positions of power and/or control, choosing occupations or recreational outlets which may put oneself in physical danger, or choosing to become a "fixer" – therapist, mediator, etc.
- ***Avoidance*** – the practice of withdrawing from relationships with other people as a defensive measure to reduce the risk of rejection, accountability, criticism or exposure
- ***Blaming*** – the practice of identifying a person or people responsible for creating a problem, rather than identifying ways of dealing with the problem
- ***Catastrophizing*** – the habit of automatically assuming a "worst case scenario" and inappropriately characterizing minor or moderate problems or issues as catastrophic events
- ***"Control-Me" syndrome*** – this describes a tendency to foster relationships with people who have controlling, narcissistic, antisocial or "acting-out" behaviors
- ***Denial*** – believing or imagining that some painful or traumatic circumstance, event or memory does not exist or did not happen
- ***Dependency*** – an inappropriate and chronic reliance by an adult individual on another individual for their health, subsistence, decision making or personal and emotional well-being
- ***Depression*** – when you feel sadder than your circumstances dictate, for longer than your circumstances last, but still can't seem to break out of it
- ***Escape to fantasy*** – taking an imaginary excursion to a happier, more hopeful place
- ***Fear of abandonment*** – an irrational belief that one is imminent danger of being personally rejected, discarded or replaced
- ***Relationship hypervigilance*** – maintaining an unhealthy level of interest in the behaviors, comments, thoughts and interests of others.
- ***Identity disturbance*** – a psychological term used to describe a distorted or inconsistent self-view
- ***Learned helplessness*** – when a person begins to believe that they have no control over a situation, even when they do

- ***Low self-esteem*** – a common name for a negatively-distorted self-view which is inconsistent with reality
- ***Panic attacks*** – short intense episodes of fear or anxiety, often accompanied by physical symptoms, such as hyperventilating, shaking, sweating and chills
- ***Perfectionism*** – the maladaptive practice of holding oneself or others to an unrealistic, unattainable or unsustainable standard of organization, order, or accomplishment in one particular area of living, while sometimes neglecting common standards of organization, order or accomplishment in other areas of living
- ***Selective memory and selective amnesia*** – the use of memory, or a lack of memory, which is selective to the point of reinforcing a bias, belief or desired outcome
- ***Self-loathing*** – an extreme hatred of one's own self, actions or one's ethnic or demographic background
- ***Tunnel vision*** – the habit or tendency to only see or focus on a single priority while neglecting or ignoring other important priorities

C-PTSD causes

C-PTSD is caused by a prolonged or sustained exposure to emotional trauma or abuse from which no short-term means of escape is available or apparent to the victim. The precise neurological impact that exists in C-PTSD victims is not well understood.

How providers can help

Little has been done in clinical studies of treatment of C-PTSD. However, in general the following is recommended:

- Removal of and protection from the source of the trauma and/or abuse
- Acknowledgement of the trauma as real, important and undeserved
- Acknowledge that the trauma came from something that was stronger than the victim and therefore could not be avoided
- Acknowledgement of the "complex" nature of C-PTSD – that responses to earlier traumas may have led to decisions that brought on additional, undeserved trauma
- Acknowledgement that recovery from the trauma is not trivial and will require significant time and effort
- Separation of residual problems into those that the individual can resolve (such as personal improvement goals) and those that the person cannot resolve (such as the behavior of a disordered family member)
- Mourning for what has been lost and cannot be recovered
- Identification of what has been lost and can be recovered
- Program of recovery with focus on what can be improved in an individual's life that is under their own control
- Placement in a supportive environment where the victim can discover they are not alone and can receive validation for their successes and support through their struggles.
- As necessary, personal therapy to promote self-discovery.
- As required, prescription of antidepressant medications.

Adapted from http://outofthefog.website/toolbox-1/2015/11/17/complex-post-traumatic-stress-disorder-c-ptsd

Mindset and Heart-set of Trauma-Informed Practice

"[Trauma-informed care] is done *for* or *with* someone, not *on* or *to* them."
Adapted from *Motivational Interviewing, 3rd edition*

Imagine taking a drink of a carbonated beverage that has gone flat. It still tastes vaguely like itself, but the fizz has gone out of it. It's no longer worth drinking, and you'll probably pour it down the drain. The spirit, or the mindset and heart-set, of providing care is the "fizz" of trauma-informed approaches.

The spirit in which we provide care and services significantly impacts people's willingness to accept our assistance. Helping is fundamentally relational – taking the form of a partnership.

Our mindset and heart-set needs to be genuine and real. It's embodied in how we carry and conduct ourselves. It's conveyed through our eyes, non-verbal expressions, and tone of voice. It's communicated in how we express ourselves. It's imparted through our attitudes and intentions. This mindset and heart-set is the essence of what people experience in our presence. Each element is briefly described below.

PARTNERSHIP
Forming a collaborative working relationship with someone; letting go of the need to be the expert; showing genuine respect for the other person's life experience, hopes, and strengths; assuming that both of you have important expertise and ideas; "dancing rather than wrestling"

ACCEPTANCE
Meeting people "where they are" without negative judgement; believing in their inherent worth *and* potential; conveying empathy – seeking to understand where they're coming from; shining a light on the strengths you see in them instead of focusing on what's wrong with them; honoring people's right to make their own decisions for themselves

COMPASSION
Coming alongside people in their suffering (e.g., trauma, mental health challenges, substance misuse, grief, stigmatization, racial injustice, denial of rights); offering the gift of a safe, listening presence; being in solidarity with; actively promoting the other's welfare, giving priority to the person's needs

EVOCATION
Inviting or "calling forth" from people what they already possess – their hopes, values, desires and aspirations; learning what people are passionate about, what they already know and can do, what they want to learn, what's important to them, how they'd like their lives to be different, what changes they're willing to consider making, and more.

Adapted from Motivational Interviewing, *3rd edition by Miller & Rollnick, 2013*

Recovery-Oriented Principles and Guidelines

"Trauma that is not transformed is transmitted."
Richard Rohr

- Remind yourself of your own values, strengths, sources of inspiration, lived experience of recovery, resilience, and hopes that you bring to this work
- Express gratitude for and take good care of your own body, mind, and spirit
- Engage in continual learning about trauma , its impact, and how to promote healing
- Remember that recovery can and does happen
- Nurture a healing-centered, recovery-oriented "mindset and heart-set" of *partnership, acceptance, compassion,* and *evocation* in providing care
- Ensure physical and emotional safety for students – create spaces and opportunities for self-regulation, quieting, expressing emotions
- Use whole-person thinking and approaches – integrate bio-psycho-social-spiritual-communal care approaches
- Focus on strengths and resilience – use "person-first" language – recognize "negative" behaviors as adaptive ways of coping – help students see and tap into their inner strengths
- Help students experience a greater appreciation of life and a deepened sense of spirituality and meaning
- Encourage individuals to expand their horizons – participate in new opportunities and activities of their choosing
- Provide opportunities for students to engage in awareness and mindfulness practices – e.g., stretching, yoga, meditation
- Encourage students to engage in robust physical exercise and play
- Promote healing through healthy interpersonal relationships
- Maximize personal choice and self-determination in all communications and actions
- Practice cultural humility and responsiveness by seeking to understand each person in the context of their life experiences and cultural background
- Solicit input and involve people seeking services in designing and evaluating services
- Address secondary traumatic stress experienced individually and collectively in your organization/team – develop self-care and team-care practices

Compiled from multiple sources

Promoting Racial and Social Equity in our Organizations

A trauma-informed approach actively promotes racial and social equity principles and practices to counteract the characteristics of white supremacy culture that often show up in our organizations. Culture is powerful precisely because it is so present and at the same time so very difficult to name or identify.

The characteristics listed below are damaging because they are used as norms and standards without being pro-actively named or chosen by the group. They are damaging because they promote white supremacy thinking.

Because we all live in a white supremacy culture, these characteristics show up in the attitudes and behaviors of all of us – people of color and white people. Therefore, these attitudes and behaviors can show up in any group or organization, whether it is white-led or predominantly white or people of color-led or predominantly people of color.

- Perfectionism
- Sense of urgency
- Defensiveness
- Quantity over quality
- Worship of the written word
- Only one right way
- Paternalism
- Either/or thinking

- Power hoarding
- Fear of open conflict
- Individualism
- I'm the only one
- Progress is bigger, more
- Objectivity
- Right to comfort

Example 1: Either/or thinking

Characteristics

- things or people are good/bad, right/wrong, with us/against us,
- results in oversimplifying complex issues
- creates conflict and increases sense of urgency
- often used by someone with a clear agenda/goal to push

Antidotes

- notice either/or language – push to come up with more than two alternatives
- notice when people are oversimplifying complex issues; slow down the process, or take a break, and encourage deeper analysis
- realize that rushing decisions takes more time in the long run

Example 2: Quantity over quality

Characteristics

- all resources of organization are directed toward producing measurable goals
- things that can be measured are more highly valued than things that cannot,
- for example, number of clients housed, percentage of clients who graduate from a program, amount of money spent are valued more than quality of relationships, democratic decision-making, ability to constructively deal with conflict

- little or no value attached to process; if it can't be measured, it has no value
- discomfort with emotion and feelings
- no understanding that when there is a conflict between content (the agenda of the meeting) and process (people's need to be heard or engaged), process will prevail (for example, you may get through the agenda, but if you haven't paid attention to people's need to be heard, the decisions made at the meeting are undermined and/or disregarded)

Antidotes

- include process or quality goals in your planning
- make sure your organization has a values statement which expresses the ways in which you want to do your work; make sure this is a living document and that people are using it in their day to day work
- look for ways to measure process goals (for example if you have a goal of inclusivity, think about ways you can measure whether or not you have achieved that goal)
- learn to recognize those times when you need to get off the agenda in order to address people's underlying concerns

Example 3: Objectivity

Characteristics

- the belief that there is such a thing as being objective or 'neutral'
- the belief that emotions are inherently destructive, irrational, and should not play a role in decision-making or group process
- invalidating people who show emotion
- requiring people to think in a linear (logical) fashion and ignoring or
- invalidating those who think in other ways
- impatience with any thinking that does not appear 'logical'

Antidotes

- realize that everybody has a world view and that everybody's world view affects the way they understand things; realize this means you too
- push yourself to sit with discomfort when people are expressing themselves in ways which are not familiar to you
- assume that everybody has a valid point and your job is to understand what that point is
- recognize that we can know things emotionally and intuitively in ways that we may
- not be able to explain "rationally;" understand that often "rational" thinking is actually an emotional response couched in logic

Adapted from Dismantling Racism: A Workbook for Social Change Groups by Kenneth Jones and Tema Okun, ChangeWork, 2001 http://www.dismantlingracism.org/

The Power of Language in Strengths-Based Approaches

The Glass Half Empty, The Glass Half Full

1. What types of messages might be communicated by the language on the left?

2. For each word, try to identify a more strengths-based term or phrase while keeping in mind the principles noted above.

3. What other words/phrases in your plans and/or language would you like to change? Why?

Deficit-based language	***Strengths-based alternative***
A schizophrenic, a borderline	
An addict/junkie	
Therapist/counselor/case manager	
Front-line staff/in the trenches	
Substance abuse/abuser	
Suffering from	
Treatment team	
High functioning/low functioning	
In denial	
Acting out	
Unrealistic	
Resistant/non-compliant	
Weaknesses/deficits	
Relapse	
Unmotivated	
Maintaining abstinence	
Entitled	
Dangerous	
Helpless	
Hopeless	
Manipulative	
Enabling	
Puts self/recovery at risk	

Adapted from Tondora, et al., (2007). Yale University School of Medicine Program for Recovery and Community Health. New Haven

What is Posttraumatic Growth (PTG)?

PTG can be confused with resilience, but the two are different constructs. "PTG is sometimes considered synonymous with resilience because becoming more resilient as a result of struggle with trauma can be an example of PTG—but PTG is different from resilience," says Kanako Taku, PhD, associate professor of psychology at Oakland University, who has both researched PTG and experienced it as a survivor of the 1995 Kobe earthquake in Japan.

"Resiliency is the personal attribute or ability to bounce back," says Taku. PTG, on the other hand, refers to what can happen when someone who has difficulty bouncing back experiences a traumatic event that challenges his or her core beliefs, endures psychological struggle (even a mental illness such as post-traumatic stress disorder), and then ultimately finds a sense of personal growth. It's a process that "takes a lot of time, energy and struggle," Taku says.

Someone who is already resilient when trauma occurs won't experience PTG because a resilient person isn't rocked to the core by an event and doesn't have to seek a new belief system, explains Tedeschi. Less resilient people, on the other hand, may go through distress and confusion as they try to understand why this terrible thing happened to them and what it means for their world view.

To evaluate whether and to what extent someone has achieved growth after a trauma, psychologists use a variety of self-report scales. One that was developed by Tedeschi and Calhoun is the Post-Traumatic Growth Inventory (PTGI) (*Journal of Traumatic Stress*, 1996). It looks for positive responses in five areas:

- Appreciation of life.
- Relationships with others.
- New possibilities in life.
- Personal strength.
- Spiritual change.

From "Life after Trauma" by Lorna Collier https://www.apa.org/monitor/2016/11/growth-trauma

Organizational Trauma-Informed Practices

How does your organization/team integrate these principles into practice? In what ways could these principles be integrated more fully?

1. Understanding Trauma and Its Impact
Ensuring that all staff are aware of the impact of traumatic stress and recognize that many behaviors and responses that seem ineffective and unhealthy in the present represent adaptive responses to past traumatic experiences.

2. Promoting Safety
Establishing a safe physical and emotional environment where basic needs are met, safety measures are in place, and provider responses are consistent, predictable, and respectful.

3. Ensuring Cultural Responsiveness
Respecting diversity within the program, providing opportunities for people receiving services to engage in cultural rituals, and using interventions specific to cultural backgrounds.

4. Supporting Control, Choice, and Autonomy
Helping people regain a sense of mastery over their daily lives. Keeping them well informed, providing opportunities to make daily decisions and create personal goals.

5. Sharing Power and Governance
Sharing power and decision-making across all levels of an organization including daily decisions and the review and creation of policies and procedures.

6. Integrating Care
Maintaining a holistic view of people receiving services and their process of healing, addressing bio-psycho-social-spiritual dimensions, facilitating communication with and among service providers and systems.

7. Promoting Healing through Healthy Relationships and Practices
Establishing safe, authentic, restorative relationships and offering opportunities and practices to promote healing.

8. Believing that Recovery is Possible
Understanding that recovery is possible for everyone regardless of how vulnerable they may appear, instilling hope by providing opportunities for involvement at all levels of the system and establishing future-oriented goals.

Adapted from C4 Innovations online course *Trauma-Informed Care: From Theory to Practice*, 2014

This work...

exhilarating
and exhausting

drives me up a wall
and opens doors I never imagined

lays bare a wide range of emotions
yet leaves me feeling numb beyond belief

provides tremendous satisfaction
and leaves me feeling profoundly helpless

evokes genuine empathy
and provokes a fearsome intolerance within me

puts me in touch with deep suffering
and points me toward greater wholeness

brings me face to face with many poverties
and enriches me encounter by encounter

renews my hope
and leaves me grasping for faith

enables me to envision a future
but with no ability to control it

breaks me apart emotionally
and breaks me open spiritually

leaves me wounded
and heals me

Ken Kraybill

Signs of Secondary Traumatic Stress

Signs of secondary stress can appear in the emotional, spiritual, interpersonal, and physical areas of one's life. Consider whether you are experiencing any of the warning signals below as a result of your work. You might also ask people close to you for their observations. Sometimes others can see us more clearly than we can see ourselves.

___ Social withdrawal
___ Low energy, fatigue
___ Feelings of being easily overwhelmed
___ Pessimistic or cynical outlook on life
___ Intrusive work-related thoughts or dreams
___ Difficulty keeping appropriate relationship boundaries
___ Difficulty setting limits, saying "no"
___ Depressed mood

___ Lack of motivation
___ Increased worry and anxiety
___ Emotional numbness
___ Feelings that no one understands (or would be able to)
___ Loss of interest in sexual activity
___ Vague physical aches, pain
___ Making poor judgments and decisions
___ Feelings of loss of control

___ Increased sense of danger or not feeling safe
___ Finding your mind wandering at work
___ Difficulty making decisions
___ Sense of disconnection from loved ones
___ Increased feelings of suspiciousness
___ Feeling "adrift" spiritually
___ Accident-proneness
___ Involvement in "risky" activities (e.g. drugs, alcohol, sexual behaviors)
___ Increased irritability, agitation

___ Feeling "on edge" much of the time
___ Feelings of despair
___ Wanting to escape, "run away from it all"
___ Increased "sick days" from work
___ Violating ethical standards
___ Reduced work productivity, doing the "bare minimum"
___ Decrease in respect for others, increase in blaming
___ Increase in obsessive thoughts and/or compulsive behaviors
___ Decreased interest in "self-care"

Adapted from Saakvitne, Pearlman, and Traumatic Stress Institute Staff, Transforming the Pain: A Workbook on Vicarious Traumatization*, 1996.*

Finding Resiliency and Renewal in Our Work

"In the event that oxygen masks may be needed, place the mask over your own face before assisting others."

Providing care for people with trauma histories involves bearing witness to tremendous human suffering, and wrestling with a multitude of complex and agonizing issues helping to address their needs. At the same time, we have the privilege of becoming partners in extraordinary relationships, marveling at the resiliency of the human spirit, and laying claim to small but significant victories. Such is the nature of this work that it can drain and inspire us all at once.

Despite the rewards inherent in the work, it inevitably exacts a personal toll. By listening to others' stories and providing a sense of deep caring, we walk a difficult path. Yet we do so willingly, knowing that first we must "enter into" another's suffering before we can offer hope and healing. It is interesting to note that the word *care* finds its roots in the Gothic "kara" which means, "lament, mourning, to express sorrow."

Caring can become burdensome, causing us to experience signs and symptoms of what the literature variously calls compassion fatigue, secondary traumatic stress, or vicarious traumatization. The impact is compounded by the frustrations of trying to provide help in the face of multiple barriers to care, including inadequate resources and structural supports for people. To feel weighed down by these circumstances is not unusual or pathological. It is, in fact, a quite normal response.

The "treatment of choice" for diminishing the negative effects of this stress is to seek resiliency and renewal through the practice of healthy self-care. Self-care is most effective when approached with forethought, not as afterthought. In the same manner that we provide care for others, we must care for ourselves by first acknowledging and assessing the realities of our condition, creating a realistic plan of care, and acting upon it. Though many providers practice self-care in creative and effective ways, we all sometimes lose our sense of balance, and fail to provide the necessary care for ourselves with the same resoluteness that we offer care to others.

To better understand what self-care is, here are three things it is *not:*

1) Self-care is *not* an "emergency response plan" to be activated when stress becomes overwhelming. Instead, healthy self-care is an intentional way of living by which our values, attitudes, and actions are integrated into our day-to-day routines. The need for "emergency care" should be an exception to usual practice.

2) Self-care is *not* about acting selfishly. Instead, healthy self-care is about being a worthy steward of the self – body, mind, and spirit – with which we've been entrusted. It is foolhardy to think we can be providers of care to others without being the recipients of proper nurture and sustenance ourselves.

3) Self-care is not about doing more, or adding more tasks to an already overflowing "to do" list. Instead, healthy self-care is as much about "letting go" as it is about taking action. It has to do with taking time to be a human being as well as a human doing. It is about letting go of frenzied schedules, meaningless activities, unhealthy behaviors, and detrimental attitudes such as worry, guilt, and being judgmental or unforgiving.

The following ABCs of self-care can provide a useful guide in reflecting upon the status of your own practices and attitudes.

AWARENESS Self-care begins in stillness. By quieting our busy lives and entering into a space of solitude, we can develop an awareness of our own true needs, and then act accordingly. This is the contemplative way of the desert, rather than the constant activity of the city. Thomas Merton suggests that the busyness of our lives can be a form of "violence" that robs us of inner wisdom. Too often we act first without true understanding and then wonder why we feel more burdened, not relieved. Parker Palmer in *Let Your Life Speak* suggests reflecting on the following question: "Is the life I am living the same as the life that wants to live in me?"

BALANCE Self-care is a balancing act. It includes balancing action and mindfulness. Balance guides decisions about embracing or relinquishing certain activities, behaviors, or attitudes. It also informs the degree to which we give attention to the physical, emotional, psychological, spiritual, and social aspects of our being or, in other words, how much time we spend working, playing, and resting. I once heard it suggested that a helpful prescription for balanced daily living includes eight hours of work, eight hours of play, and eight hours of rest!

CONNECTION Healthy self-care cannot take place solely on one's own. It involves being connected in meaningful ways with others and to something larger. We are decidedly interdependent and social beings. We grow and thrive through our connections that occur in friendships, family, social groups, nature, recreational activities, spiritual practices, therapy, and myriad other ways. Often times, our most renewing connections can be found right in our midst in the workplace, with co-workers and with the individuals to whom we provide care.

There is no formula of course for self-care. Each of our "self-care plans" will be unique and change over time. We must listen well to our own bodies, hearts, and minds, as well as to the counsel of trusted friends, as we seek resiliency and renewal in our lives and work.

Fasten your seatbelts and enjoy the ride!

Ken Kraybill

Self-Assessment Tool: Self-Care

How often do you do the following? (Rate, using the scale below):

5 = Frequently
4 = Sometimes
3 = Rarely
2 = Never
1 = It never even occurred to me

Physical Self Care

- ☐ Eat regularly (e.g. breakfast & lunch)
- ☐ Eat healthfully
- ☐ Exercise, or go to the gym
- ☐ Lift weights
- ☐ Practice martial arts
- ☐ Get regular medical care for prevention
- ☐ Get medical care when needed
- ☐ Take time off when you're sick
- ☐ Get massages or other body work
- ☐ Do physical activity that is fun for you
- ☐ Take time to be sexual
- ☐ Get enough sleep
- ☐ Wear clothes you like
- ☐ Take vacations
- ☐ Take day trips, or mini-vacations
- ☐ Get away from stressful technology such as pagers, faxes, telephones, e-mail
- ☐ Other:

Psychological Self Care

- ☐ Make time for self-reflection
- ☐ Go to see a psychotherapist or counselor for yourself
- ☐ Write in a journal
- ☐ Read literature unrelated to work
- ☐ Do something at which you are a beginner
- ☐ Take a step to decrease stress in your life
- ☐ Notice your inner experience - your dreams, thoughts, imagery, feelings
- ☐ Let others know different aspects of you
- ☐ Engage your intelligence in a new area - go to an art museum, performance, sports event, exhibit, or other cultural event
- ☐ Practice receiving from others
- ☐ Be curious
- ☐ Say no to extra responsibilities sometimes
- ☐ Spend time outdoors
- ☐ Other:

Emotional Self Care

- ☐ Spend time with others whose company you enjoy
- ☐ Stay in contact with important people in your life
- ☐ Treat yourself kindly (supportive inner dialogue or self-talk)
- ☐ Feel proud of yourself
- ☐ Reread favorite books, review favorite movies
- ☐ Seek out comforting activities, objects, people, relationships, places
- ☐ Allow yourself to cry
- ☐ Find things that make you laugh
- ☐ Express your outrage in a constructive way
- ☐ Play with children
- ☐ Other:

Spiritual Self Care

- ☐ Make time for prayer, meditation, reflection
- ☐ Spend time in nature
- ☐ Participate in a spiritual gathering, community or group
- ☐ Be open to inspiration
- ☐ Cherish your optimism and hope
- ☐ Be aware of nontangible (nonmaterial) aspects of life
- ☐ Be open to mystery, to not knowing
- ☐ Identify what is meaningful to you and notice its place in your life
- ☐ Sing
- ☐ Express gratitude
- ☐ Celebrate milestones with rituals that are meaningful to you
- ☐ Remember and memorialize loved ones who have died
- ☐ Nurture others
- ☐ Contribute to or participate in causes you believe in
- ☐ Read inspirational literature
- ☐ Listen to inspiring music
- ☐ Other:

Workplace/Professional Self Care

- ☐ Take time to eat lunch
- ☐ Take time to chat with co-workers
- ☐ Make time to complete tasks
- ☐ Identity projects or tasks that are exciting, growth-promoting, and rewarding
- ☐ Set limits with clients and colleagues
- ☐ Balance your caseload so no one day is "too much!"
- ☐ Arrange your workspace so it is comfortable and comforting
- ☐ Get regular supervision or consultation
- ☐ Negotiate for your needs
- ☐ Have a peer support group
- ☐ Other:

Adapted from Saakvitne, Pearlman, and Traumatic Stress Institute Staff, *Transforming the Pain: A Workbook on Vicarious Traumatization, 1996.*

Selected Resources: Trauma-Informed Care

ACES Connection Resources Center https://www.acesconnection.com/g/resource-center

Bassuk, E.L., Olivet, JO, Winn, LP, & Nichols, K. (2014). Safety in Support: An Interactive eBook on Trauma-Informed Care. Available from the ibooks library.

C4 Innovations: The TICOMETER©, a psychometrically-validated instrument that measures the degree to which an organization is engaged in trauma-informed practices https://c4innovates.com/training-technical-assistance/trauma-informed-care/ticometer/

Childhood Trauma: Changing Minds https://changingmindsnow.org/. Includes videos:

Herman, J. (1992). Trauma and recovery. New York: Basic Books.

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. The Open Health Services and Policy Journal, 3, 80-100.

National Child Traumatic Stress Network www.nctsn.org

National Council for Behavioral Health. Trauma-Informed Behavioral Health Care Trauma-Informed Care Organizational Self-Assessment http://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare

Pinderhughes H, Davis R, Williams M. (2015). Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma. Prevention Institute, Oakland, CA https://www.preventioninstitute.org/sites/default/files/publications/Adverse%20Community%20Experiences%20and%20Resilience.pdf

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

SAMHSA: A Guide to GPRA Data Collection Using Trauma-informed Interviewing Skills, 2015 https://www.integration.samhsa.gov/about-us/Trauma-InformedInterviewingManual-508.pdf

SAMHSA National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint http://www.samhsa.gov/nctic

Step Inside the Circle https://vimeo.com/398088783?ref=fb-share&fbclid=IwAR0LHH3xl3AztDAI40LwxazwjR5tbiL0H07PPpn-6YSFwQ2J4ZDhPoIbhYo

The Trauma Center at Justice Resource Institute http://www.traumacenter.org

Through a Darker Lens: The Trauma of Racism in Communities of Color https://www.pathwaysrtc.pdx.edu/pdf/fpS1507.pdf

van der Kolk, Bessel. (2014). The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. New York: Viking

Selected Online Videos: Trauma-Informed Care

What is trauma-informed care? https://youtu.be/fWken5DsJcw

Empathy: The Human Connection to Patient Care https://youtu.be/cDDWvj_q-o8

Changing Minds Now https://changingmindsnow.org/healing

"Chad" https://www.youtube.com/watch?v=sFH6GR0ASKg

"Unique" https://youtu.be/NRIECTLFhkM

Toxic stress derails healthy development https://youtu.be/rVwFkcOZHJw

Trauma and the Brain https://youtu.be/ZLF_SEy6sdc

Emotional Regulation Techniques for Anxiety, Panic Attacks, Anger and Depression (Jason Halliwell) https://youtu.be/l6rrcqoKniQ

Father and Toddler Having Conversation https://youtu.be/Yn8j4XRxSck

What Trauma Taught Me About Resilience (Charles Hunt)
https://www.youtube.com/watch?v=3qELiw_1Ddg

Important Facts about Resilience: A Consideration of Research Findings about Resilience and Implications for Assessment and Treatment
https://www.melissainstitute.org/documents/facts_resilience.pdf

Attachment and Resilience – The Power of One (Dr. Erica Liu Wollin)
https://www.youtube.com/watch?v=C-ZIUtJr8nE

See No Stranger (Valery Kaur) https://youtu.be/QKMEqF0OVxs