TRAUMA-INFORMED PRACTICE: OVERARCHING THEMES AND PATTERNS IN BECOMING TRAUMA-INFORMED

by

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Abstract

Services can do undue harm to clients when there is a lack of understanding of the effects of trauma from various adverse life events on an individual's functioning. A trauma-informed organization provides care, compassion, and respect toward clients and staff with the understanding that each individual may have experienced trauma in their lifetime. The goal of a trauma-informed organization is to meet clients who have lived through trauma where they are at in their healing journey and prevent re-traumatization.

My project focused on elucidating the main themes that are pertinent for an organization to become trauma-informed. I utilized content analysis to examine five trauma-informed organizations' guidebooks from health, child-welfare, education, counselling, and community housing service sectors and created a trauma-informed guidebook. My guidebook outlines eight trauma-informed themes – safety, trust, collaboration, choice, culture, staff, listening, and resiliency – and examples of these themes in practice from the aforementioned service contexts.

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Introduction

Trauma is the experience of an adverse event that involves normal responses and reactions to an abnormal situation (van der Kolk, 2015). Trauma does not discriminate; ourselves, our friends, family, neighbours and the people around us experience it. A vast amount of research has focused on working with trauma survivors through a top-down, bottom-up, or medical approach (van der Kolk, 2015); however, research has recently shifted in the direction of organizations and communities to become trauma-informed. A trauma-informed lens means that when working with clients, an organization avoids the potential of re-traumatization by interacting in a safe, respectable, and compassionate way with the awareness clients may have experienced trauma (Harris & Fallot, 2001). Integrating a trauma-informed lens into a system that is already in place is a daunting and arduous task, however, not impossible. Throughout North America, various organizations have adopted a trauma-informed lens to serve clients through best practice wherein services are appropriate and welcoming to individuals who have experienced trauma. As the shift is en-route for various health, social, justice and educational institutions in becoming trauma-informed, many organizations have yet to begin the transition into a trauma-informed service; additionally, trauma-informed care has made slower progress at a community level.

For this project, I examined organizations from education, child-welfare, community housing, substance use, and counselling and health service sectors to assess how a trauma-informed lens was adopted. Each trauma-informed organizations' guidebook was studied to seek out core themes and patterns that are imperative to ensure that trauma-informed care is established. Further, I elaborate on the purpose of the project, followed by a discussion of parameters, significance, benefits, and finally the background of the project.

Chapter One

Purpose of the Project

To begin the development of this project, I sought out factors that organizations have in place to ensure a trauma-informed lens is utilized. By identifying what works in practice, I identified themes and patterns that institutions have in place to help serve clients in a compassionate and respectful manner. Furthermore, I elucidated service areas that are absent and require additional support in becoming trauma-informed. Ultimately, I created a general guidebook that illustrates themes and examples of trauma-informed in practice that can guide organizations to understand the important underlying factors in becoming trauma-informed.

Significance of the Project

The effects of trauma have a wide array of consequences on survivors, ranging from psychological, emotional, physical, social and spiritual detriments (van der Kolk, 2013). When organizations and communities are unencumbered by the impact trauma has on present-day behaviours and survival skills that clients and staff experience, systems set themselves up for failure in providing adequate and sensitive care. In turn, clients can leave feeling more hopeless, helpless, vulnerable, hurt, confused, frustrated, and angry than when originally seeking help; thus, clients may be turned off of the potential to seek help in the future because of their adverse experiences within the system (Harris & Fallot, 2001). In addition, staff run the risk of experiencing adverse effects of secondary trauma, which is the experience of trauma-like symptoms by being exposed to a client's traumatic story (Elwood, Mott, Lohr, & Galovski, 2011).

In light of the inadvertent harm that may be posed to clients and staff, an evaluation of organizations that are trauma-informed has not been widely documented within the literature.

Further, there has been limited research on evaluating core themes across organizations from varying disciplines that already implement trauma-informed practices. Rather, the majority of trauma-informed resources provide a step-by-step guidebook on how to transform an agency into a trauma-informed practice within a particular discipline. Therefore, what distinguishes my project is I evaluated themes that are consistent across differing workplace organizations utilizing a trauma-informed practice.

Benefits. The potential benefits of my project are twofold. First, shifting practices within organizations towards trauma-informed care will allow for the prevention of re-traumatization among current and prospective clients. By being trauma-informed, each client can be served in a manner that understands their symptomologies and ways of coping where organizations can respond ensuring that clients feel safe.

Secondly, a trauma informed lens would benefit staff members within each organization. Staff members can experience burnout and run the risk of suffering the negative effects of secondary trauma when working with survivors of trauma. Secondary trauma is defined as trauma responses and symptomatology taken upon the helper from hearing content-specific stories of a client (Trippany, White Kress, & Willcoxon, 2004). By utilizing a trauma informed lens, management within organizations could take necessary precautions to ensure that staff are able to perform to their best ability without suffering undue harm and secondary trauma.

Parameters of the Project. Using content analysis, I created an integrated summary synthesized into a general guidebook consisting of themes, examples of the theme in practice, and appendices of further resources. However, this is not an in-depth guidebook that provides a step-by-step process of transforming an organization into a trauma-informed service. A step-by-step process for creating a trauma-informed practice will vary depending upon the context that it

is introduced in; however, becoming trauma-informed is an ongoing process rather than a single step implementation (Harris & Fallot, 2001).

Furthermore, the required resources needed to implement a trauma-informed organization are beyond the scope of the present project. Resources refer to funding, long-term cost/benefits of implementing a trauma-informed lens, training for staff and clients, and organizational management. Additional research in specific organizational fields is required in order to illuminate the necessary step-by-step criteria to become trauma-informed.

Background of the Project

From my own work with families and individuals, an ever-present focus on understanding "What has happened to clients?" versus "What is wrong with clients?" has allowed for a greater potential of relationship building, exploration, and healing from trauma. A clinician operating from a "What happened" stance will understand the circumstances and resulting effects of these situations on a client, whereas a "What is wrong" stance can create blame upon the client that the circumstance is their fault. Many of the clients that I have journeyed with experienced a plethora of concerns surrounding addictions, relationships, feelings of instability, and a loss of control. Much of their dismay stemmed from adverse childhood experiences wherein I felt helpless to be of assistance due to the lack trauma-informed knowledge received from the agency where I was employed. Working with my clients was slow, arduous, and lacked any perceived benefit to them. We would set out goals, establish strategies, and attempt to implement change, however what hindered was the un-addressed trauma and the lack of care and compassion that they would receive from other organizations. Therefore, the present research holds dear to me insomuch that the importance of a trauma-informed lens can

provide care that holds the utmost respect towards people being served who have experienced and are experiencing trauma.

Moreover, through my present work in counselling individuals, couples, and group, trauma persists and is prevalent in approximately 80% of my caseload. Clients present with varying degrees of distress which have roots far reaching into their past histories. Initial engagement with these clients is difficult and progress is sometimes slow, especially in light of the fact that a central focus of our work is on the mistreatment that they have received while in the 'system'. Mistreatment has included feelings of blame, guilt, and shame for what has happened to the client as well as the sharing of traumatic events too quick, too soon. As a result, many clients feel wary and weary of engaging in social services that are designed to help individuals in need and in turn, left them to feel more hopeless and helpless. To be more informed about how to facilitate work with these clients, I have completed a trauma-informed counselling course. This course has afforded me the opportunity to understand the consequences of trauma and taught me to meet clients where they are. Moving this into my own practice, I have ensured that a safe, trusting, collaborative, and empowering environment is provided for my clients so that a relationship is built and bolstered first and foremost. Through understanding a client's trauma experience, a safe therapeutic environment and relational rapport is established. These relationships have allowed for a strong foundation for work to move forward and for clients to begin healing from past hurt. Thus, my present work is indicative of the importance of embracing a trauma-informed lens in order to prevent undue harm to clients by inadvertent re-traumatization.

Overview of the Project

The present project emphasizes the importance and efficacy of adopting a trauma informed lens in health, child-welfare, community, and educational services. Adopting a trauma informed lens can allow agencies to serve clients in an efficient, non-retraumatizing manner. As guidebooks, progress reports, and evaluations are released from individual organizations outlining the efficacy of trauma-informed practice, the conversation can begin between organizations and eventually shift toward a conversation among the community. The goal of the shift would be to provide best care practice to those who have experienced trauma. Ultimately, I elucidated factors of trauma informed care within organizations that have adopted the practice through a content analysis of their published work.

Chapter Two: Literature Review

Trauma

Trauma is considered a reaction to an event that leaves an individual feeling helpless, in horror, and with physical distress; the trauma narrative includes suffering that fragments the mind and the body resulting in a variety of difficult symptoms such as dissociation, numbing, anxiety, and depression (Williams, 2006). Individuals who experience significant events that are psychologically overwhelming for their internal resources to manage exhibit adverse after-effects of trauma (Briere & Scott. 2006); however, there has been much contention surrounding the Diagnostic Statistic Manual of Mental Disorders version 5 (DSM-5) in the characterization of trauma. The DSM-5 describes trauma and stress-related disorders through specific diagnoses (such as Post Traumatic Stress Disorder (PTSD) that are limiting of the wide array of significant experiences that can cause an event to be traumatic for an individual. Specifically, PTSD within the DSM-5 is diagnosed based on a subset of circumstances that and individual must undergo, such as domestic abuse, sexual abuse, kidnapping, death, etc., in order to be characterized as ailing from PTSD (American Psychiatric Association, 2013). Briere & Scott (2006) emphasize that the DSM-5 discounts trauma that is outside of the categories that characterize events as traumatic. Additionally, the DSM-5 does not recognize patterns of trauma that are prevalent within the literature, for example, complex PTSD which is widely used in trauma literature has not been afforded a diagnosis within the DSM-5 (van der Kolk, 2013).

A further limitation of the DSM-5 is the lack of acknowledgement toward secondary trauma. What appears to be missing is the acknowledgment of the extant research on the "costs of caring" (Beck, 2011). These costs of caring can result in staff becoming indirectly affected and experiencing similar PTSD symptoms as the person who they are working with which

experienced trauma (Trippany, White Kress, & Willcoxon, 2004). The DSM-5 should include specifics relating to secondary and complex trauma in order to better serve those who are suffering related symptomatology. Additionally, recognition will allow staff to receive adequate support and funding to access support services for working in distressing environments. Further, I elaborate on the following sections: complex trauma, secondary trauma, moving from knowledge to practice, and finally, trauma-informed and trauma-specific care.

Complex Trauma/PTSD

The long-term sequelae of trauma can result in complex psychological trauma when there is repetitive, prolonged exposure to adverse events (Courtois & Ford, 2009). Within the developmentally sensitive years, witnessing or experiencing violence including physical abuse, emotional abuse, and neglect from caregivers or responsible adults can leave a child with a fragmented sense of self and a contorted personality (Williams, 2006). The experience of complex psychological trauma is defined as complex due to the compounding nature and timing of the severe experience; the experience is generally chronic and infiltrates the individual's abilities to form secure attachments (Courtois & Ford, 2009). Therefore, the definition of complex trauma is much more extensive than the traditional diagnosis of PTSD where a dearth of research has emerged separating complex PTSD from PTSD (van der Kolk, 2013). Traditionally, PTSD was first ascribed to soldiers who have lived through combat, but van der Kolk (2013) noticed that other populations other than veterans (victims of domestic violence and child abuse) experienced complex trauma symptomologies. As a result, a clear and present concern is denoted when the DSM-5 rejects complex PTSD due to the lack of research on the distinctiveness and pervasiveness of the disorder (Friedman, 2013).

Secondary Trauma

Therapists, nurses, doctors, and others in the helping profession who work and care for client's that have experienced trauma run the risk of experiencing PTSD symptomology that is secondary in nature (Elwood, Mott, Lohr, & Galovski, 2011). By witnessing another's experience of trauma, helpers can experience PTSD-like symptoms such as sadness, depression, anxiety, and sleep disturbances (Conrad & Keller-Guenther, 2006). Considering secondary trauma through a trauma-informed lens means that grave consideration must come into place not only for clients served, but also for the staff who are serving them. Within organizations, it is important for upper management to consider the impacts of the work provided and subsequently implement resources to ensure staff wellness and longevity. Ensuring safety for staff falls upon the responsibility of each organization to take the necessary steps in preventing secondary trauma, and to provide the necessary support if secondary trauma occurs. Steps that organizations can take to provide staff care include, but are not limited to, regular supervision, facilitating collegiality, team-building exercises, monitoring staff client-loads and workloads, and debriefing following experiencing an intense event (Sabin-Farrell & Turjn, 2003).

Research continues to emerge (Beck, 2011; Conrad & Kellar-Guenther, 2006; Elwood, Mott, Lohr & Galovski, 2011; & Sabin-Farrell & Turjn, 2003) illuminating the fact that staff can experience secondary traumatic stress who are not directly exposed to the traumatic event but rather exposed to the story that a traumatized individual experiences. Thus, ensuring that staff have the adequate resources to deal with secondary trauma is incumbent upon the organization where they work.

From Knowledge to Practice

Despite the contention within the DSM-5 and the trauma literature, engaging with individuals who have experienced trauma or have been exposed to traumatic stories in the community must be done with the utmost care and respect if we are to help heal through the horrors that they have experienced. Van der kolk (2012) refers to the horrors and mark that trauma leaves on individuals as "black holes," where experiences can shift biological, social and psychological equilibriums to the extent that an individual remains stuck in the past event[s]. Individuals who experience trauma have their lives surrounded, organized, and defined by their trauma; therefore, in understanding how trauma lays its mark on individuals can we begin to help the healing and post-traumatic growth process. However, when survivors of trauma interact with social, health, government and judicial systems they run the risk of becoming re-traumatized in every setting that they encounter (Klinic, 2013). In these settings, providers run the risk of not fully understanding the impacts that trauma leaves on survivors and the subsequent negative symptoms that can remain for years following the traumatic event. When providers help, they may inadvertently and unintentionally leave clients feeling misunderstood, unsupported, and even blamed (Richardson, Coryn, Henry, Black-Pond, & Unrau, 2012). These systems serve survivors of trauma without awareness that the trauma has occurred or without consideration of the consequences of those traumatic experiences (Harris & Fallot, 2001). Embracing a trauma-informed and trauma-specific practice can allow service providers the opportunity to help survivors and staff in a safe, caring, and compassionate manner. The prevention of re-traumatization begins with organizations and communities embracing the conversation of becoming trauma-informed working with clients and staff.

Trauma-Informed Care

When systems serve clients in manners that re-traumatize them, not only is harm done, but also trauma continues to successfully hide in plain view. In order for systems to prevent undue harm to clients a trauma-informed care approach is foundational to begin healing. Trauma-informed care (TIC) means an engagement with clients while holding an understanding that every client has possibly experienced trauma in their lifetime (Wolf, et al., 2014). This engagement includes service provision that emphasizes safety, resiliency, choice, and control (Harris & Fallot, 2001). Adopting a TIC lens from a direct-service point-of-view means that when clients are served, from their first interaction with the receptionist, all the way to the clinician/supervisor, they are treated in a welcoming and appropriate manner. For example, when clients enter an appointment, they are greeted, told their expected wait time, and offered a beverage. Thus, TIC represents an organization's commitment to providing services that take into special consideration the special needs of trauma survivors (Harris & Fallot, 2001). Wolf, et al., (2014) explains that if organizations subscribe to a TIC lens on all levels, five basic polices of TIC must be adhered to: safety, trustworthiness, collaboration, empowerment, and choice for both clients and staff members.

Moreover, a trauma-informed organization does not need to focus on treating symptoms or consequences of trauma (which is the job of trauma-specific services) but rather to provide services that are respectful of the trauma that clients have survived through. Harris & Fallot (2001) elaborate that to be trauma informed means to understand the history and current trauma in the life of the client with who is seeking service; from "What is wrong with you?" to "What has happened to you?" Service providers often gather glimpses and are thrown into client's stories at the middle, without an understanding of the beginning. Through gaining clarity of a

client's history, a holistic and integrated treatment plan can be arranged that is sensitive to the vulnerabilities of survivors, but also include client participation in treatment. Providers can then discern what types of services a client needs to access and consults with the client regarding options that can be pursued. Thus, TIC is a "universal design" for serving trauma survivors in that it is provided to all, by all (Goodman, et al., 2016).

Trauma Specific

In contrast, trauma specific services and interventions serve to treat the actual sequelae of PTSD and other trauma-related symptoms (Wolf, et al., 2014). Trauma specific interventions are offered by trauma specific organizations and often involve therapeutic interventions from trained specialists; for example, eye movement desensitization and reprocessing by Francine Shapiro and cognitive behavioural therapy are trauma specific interventions that can be provided by trained therapists.

Summary

In the literature, tension surrounding the DSM-5 and the lack of recognition for varying types of trauma are evident. These complexities of trauma and its widespread effects that it leaves on those who have experienced trauma have been well documented. As clients seek assistance for their experience of trauma they run the risk of becoming re-traumatized while staff run the risk of experiencing secondary trauma. To curb these deleterious effects from seeking help, health, justice, social and education providers can benefit from adopting a trauma-informed lens. In the adoption of TIC, clients can be served and their symptomatology that they exhibit understood, rather than being judged. Through this understanding, the protection of both clients and staff can be ensured so that care and compassion is exhibited at each step along the healing journey.

Chapter Three: Project Plan

Introduction

The following project highlights strategies and practices that are currently in place in varying mental health organizations that implement a best practice, trauma-informed lens when working with clients. Trauma-informed is not a one-step implementation, but rather an ongoing process of compassionate caring and understanding to both clients and staff who suffer from mental, physical, and spiritual pain due to trauma.

My project was completed through a self-directed examination of organizations that ascribe to a trauma-informed practice. I utilized the process of content analysis with each organization's published guidebook.

Content Analysis

Content analysis is a research paradigm that is used within the health services and has widely been used within nursing practices to qualitatively analyze data (Hsieh & Shannon, 2005). Content analysis is a research method that adds context by creating replicable and valid inferences from dissecting data (Elo & Kyngäs, 2007); it is a way to reduce large amounts of data and systematically create meaning (O'Neill, Fraser, Kitchenham, & McDonald, 2016). Specifically, content analysis aims to create a broad elaboration of the presenting phenomenon by creating a model, guidebook, or conceptual map through the literature that is reviewed.

In my research, I examined various organizations from differing contexts that ascribe to a trauma informed lens for practice. Inclusion criteria was English speaking programs from 1990 to 2016 under the topics of trauma informed practice, trauma informed care, trauma informed systems, trauma informed organizations, and trauma informed community. Literature included guidebooks and organizational manuals that have been published for public access. My search

focused on five organizations from the health, education, child-welfare, counselling, and community housing sectors.

Self-Directed Examination

I conducted a content analysis of five organizations that ascribe themselves to following a trauma-informed practice. The following organizations were examined: The Jean Tweed Centre, Chadwick Centre for Children and Families, The Australian Childhood Foundation, Potrero Hill Community Building, and the Manitoba Trauma Information and Education Centre. Each organization is elaborated upon in my guidebook. Through my examination of the aforementioned services, core themes and patterns have been highlighted that support a trauma-informed lens. My orientation in identifying themes and patterns focused on processes, methodologies, strategies, and positive outcomes that have benefitted clients in a caring and compassionate manner. Each organization examined was from a different service sector, thus, themes identified are broad, all-encompassing, and not program specific, which is beyond the scope of this project.

The organization's guidebooks that I have chosen to examine is based upon knowledge that has been made public regarding practices that are currently implemented; these programs were sought out via Google, Google Scholar, Medline, and Psych-info library search.

Furthermore, in researching these various organizations I engaged in an inductive-iterative process. Inductive qualitative research posits that themes and patterns emerge from the data under examination, whereas deductive research views data with a preset theoretical lens (Srivasta & Hopwood, 2009). As data was uncovered, an iterative reflexive process was employed whereby data informed key themes and processes that were used to inform subsequent

analysis; thus, there was a back and fourth from the data to the themes, and from the themes to the data in order to refresh insights and reach saturation (Srivasta & Hopwood, 2009).

Outcome

Upon reviewing trauma-informed organizations in both the local and broader community through content analysis, I created a general guidebook of overarching themes that are pertinent to address in order to provide trauma-informed care within an organization. As organizations begin the discussion of shifting toward a trauma-informed practice, this guidebook can serve as a starting point to begin the dialogue of what areas need to be addressed to become a trauma-informed service.

My guidebook consists of a framework that supports larger themes from the data (e.g., safety, collaboration, etc.) and examples of these themes in practice. Additionally, it includes appendices with further resources on the 'how to' transform an organization into a trauma-informed practice. Ideally, from a community level, these themes will function as an outline and overarching umbrella that can begin the discussion and identification of factors in the importance of adopting a trauma-informed lens.

Summary

My project was completed utilizing a content analysis of organizations that currently implement a trauma-informed lens and factors that are effective in preventing undue harm and re-traumatization were identified. Ascribing to a trauma-informed lens can prevent re-traumatization amongst clients and staff who have experienced trauma while on their healing journey. Finally, I have created an integrated summary of themes and patterns of trauma-informed practice that can help inform services toward a paradigm shift of compassionate,

trauma-informed caring. Organizations can then use the guiding principles to create a trauma-informed practice that is specific to their context of service provision.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Beck, C. T. (2011). Secondary traumatic stress in nurses: A systematic review. *Archives of Psychiatric Nursing, 25*(1), 1-10. doi:10.1016/j.apnu.2010.05.005

Briere, J. & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluations, and treatment*. Sage Publications, Thousand Oaks, CA.

Conrad, D. & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect, 30*, 1071-1080. doi:10.1016/j.chiabu.2006.03.009

Courtois & Ford (2009). *Treating Complex Traumatic Stress Disorders (Adults): Scientific Foundations and Therapeutic Models*. Guildford Press, New York, NY.

Elo S. & Kyunga, S. H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107–115. doi: 10.1111/j.1365-2648.2007.04569.x

Elwood, L. S., Mott, J., Lohr, J. M., & Galovski, T. E. (2011). Secondary trauma symptoms in clinicians: A critical review of the construct, specificity, and implications for trauma-focused treatment. *Clinical Psychology Review, 31*, 25-36. doi:10.1016/j.cpr.2010.09.004

Friedman, M. J. (2013). Finalizing PTSD in DSM-5: Getting here from there and where to go next. *Journal of Traumatic Stress, 26*, 548–556. doi:10.1002/jts.21840

Goodman, L. A., Sullivan, C. M., Serrata, J., Perilla, J., Wilson, J. M., Fauci, J. E., & DiGiovanni, C. D. (2016). Development and validation of the trauma-informed practice scales. *Journal of Community Psychology, 44*(6), 747-764. DOI: 10.1002/jcop.21799

Harris, M., & Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New directions for Mental Health Services, 89*, 3-22.

Hsieh, H-F. & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288. DOI: 10.1177/1049732305276687

Klinic Community Health Centre. (2013). The trauma informed toolkit: Second edition. Retrieved from: http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

O'Neill, L., Fraser, T., Kitchenham, A., & McDonald, V. (2016). Hidden Burdens: a Review of intergenerational, historical, and complex trauma, implications for indigenous families. *Journal of Child Adolescent Trauma*.

Richardson, M. M., Coryn, C. L. S., Henry, J., Black-Pond, C., & Unrau, Y. (2012). Development and evaluation of the trauma-informed system change instrument: Factorial validity and implications for use. *Child Adolescent Social Work Journal, 29*, 167-184.

Sabin-Farrell, R. & Turpin, G. (2003). Vicarious traumatization: Implications for mental health of health workers? *Clinical Psychology Review, 23*, 449-480. doi:10.1016/S0272-7358(03)00030-8

Srivasta, P. & Hopwood, N. (2009). A practical iterative framework for qualitative data analysis. *International Journal of Qualitative Methods, 8*(1), 76-84.

Trippany, R. L., White Kress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development, 82*, 31-37.

Van der Kolk, B. A., McFarlance, A. C. (2012). *Traumatic stress: The overwhelming experience on mind, body and society*. Guildford Press, New York, NY.

Van der Kolk, B. A. (2015). *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. Penguin Group, New York, NY.

Van der Kolk, B. A. (2013). Interview: What is PTSD really? Surprises, twists of history, and the politics of diagnosis and treatment. *Journal of Clinical Psychology: In Session, 69*(5), 516-522.

Williams, W. I. (2006). Complex trauma: Approaches to theory and treatment. *Journal of Loss and trauma, 11*. 321-355.

Wolf, M. R., Green, S. A., Nochajski, T. H., Mendel, W. E., & Kusmaul, N. S. (2013). 'We're civil servants': The status of trauma-informed care in the community. *Journal of Social Service Research, 40*, 111-120. DOI: 10.1080/01488376.2013.845131

Trauma-Informed Practice:

Overarching Themes and Patterns in Becoming Trauma-Informed

Kyle Poon, M.Ed.

Table of Contents

Overview

The following guidebook includes an integrated summary of trauma-informed practice themes that have been synthesized from various health, child welfare, education, and community trauma-informed organizations. This summary will outline common themes of trauma-informed work that are persistent and pertinent to consider when working with clients and staff.

Questions this Guidebook Will Cover

- *What is trauma-informed practice?*
- *Why is trauma-informed practice important?*
- *What general themes are important to consider in becoming a trauma-informed organization?*
- *What do these themes look like across various contexts and service sectors?*

How to Use this Guidebook

The general themes covered in this integrated summary are intended to guide organizations in shifting toward trauma-informed practice. The themes in this guide come from an examination of five organizations of varying service contexts that have implemented a trauma-informed practice. Each theme will be accompanied by examples of how current trauma-informed agencies adopt the themes into practice. Examples provided will demonstrate practice on a direct service level (i.e., frontline work with clients) and from an organizational level (i.e., administration and policies and procedures).

The themes covered in this guidebook are not to be utilized as all-or-nothing factors in becoming trauma-informed. Rather, each general theme is intended for organizations to review how these constructs fit within their scope of practice. Each theme will vary in how it is adopted depending on the context of practice. Your organization may include more themes or less themes. It is ultimately upon each organization to decide how to implement the tools and service delivery from the general themes provided.

Furthermore, a step-by-step process of how to become trauma-informed is beyond the scope of this guidebook. However, additional links and resources are included in the appendices to further your organization into a trauma-informed practice. Resources offer education, training, and step-by-step processes of how to become trauma-informed from both a service delivery perspective and on a policy and procedure level.

Introduction

What is Trauma?

Trauma is the experience of an adverse event that involves normal responses and reactions to an abnormal situation (van der Kolk, 2015). The intensity of the traumatic experience overwhelms one's capacity to cope. Events can include, but are not limited to, experiencing child abuse, neglect, violence, natural disasters, loss, and any event that is outside of an individual's control. Trauma does not discriminate; it is experienced by ourselves, our friends, family, neighbours and the people around us.

What Do the Numbers say?

Many individuals who have experienced trauma do not seek services specifically addressing their trauma. However:

- 90% of public mental health clients have been exposed to trauma (Goodman, et al., 1997)
- 76% of adults in Canada report some form of experience and/or exposure to trauma in their lifetime (Van Ameringen, et al., 2008)
- 9.2% of Canadian adults meet the criteria for post-traumatic stress disorder (PTSD) (Van Ameringen, et al., 2008)

What is Trauma-Informed?

Trauma-informed practice is a way to provide service delivery to both clients and staff in a caring and compassionate manner with the understanding that an individual may have experienced trauma. Working with a trauma-informed lens means that an organization avoids the potential of re-traumatizing clients by cultivating an atmosphere of safety, nonviolence, collaboration, and learning (Harris & Fallot, 2001). For example, a client who has experienced abuse in the past is triggered by language that holds blame and shame. If this client interacts with a provider who uses language in the same manner, they risk being re-traumatized by re-experiencing painful emotions as if the traumatic experience was occurring.

Whether it is an organization's policies and procedures, administrative staff, supervisory staff, or front-line staff, a trauma-informed service ensures all aspects of the organization adhere to safe and collaborative caring. Thus, it is imperative that all levels of an organization are trauma-informed to best serve the community.

Becoming a trauma-informed organization is an ongoing process rather than a one-time transformation. It is a continuous negotiation among clients and staff and a continuous adjustment to community needs. Being trauma-informed does not mean searching clients for a full disclosure of trauma, rather it is a way of recognizing that safety and trust are at the forefront of care.

Furthermore, trauma-informed organizations do not focus on solely treating the effects of trauma, rather this is the role of trauma-specific services. Trauma-specific services and interventions serve to treat the actual effects of PTSD and other trauma-related symptoms (Wolf, et al., 2013). Trauma-specific interventions are offered by trauma-specific organizations and often involve interventions from trained therapists. For example, eye movement desensitization and reprocessing by Francine Shapiro and cognitive behavioural therapy are trauma specific interventions that can be provided by trained therapists.

Why Become Trauma-Informed?

To understand the importance of a trauma-informed practice, it is first imperative to understand the effects of trauma. Trauma can leave individuals suffering from a wide array of debilitating symptoms such as, but not limited to, anxiety, terror, disconnection, shame, helplessness, loss of control, dissociation, depression, irritability, sleep disturbances, and nightmares. The experience of trauma can affect an individual on all spectrums from physical, emotional, psychological and spiritual well-being. The responses and reactions to trauma can interfere with an individual's day-to-day functioning, feelings of safety, sense of self, building and maintaining relationships, and difficulties alleviating and regulating distressing emotions. When clients interact with services and exhibit these symptomatology, they run the risk of service providers not understanding the backstory of what has happened. Often, when engaging with an individual suffering from these symptoms a quick response such as, "What is wrong with you?" can be common which incites blame and shame upon the individual seeking help. Therefore, a shift is needed from asking the question of, "What is wrong with you?" to "What has happened to you?" (Harris & Fallot, 2001).

Thus, the goal of becoming trauma-informed is to avoid re-traumatization and undue harm when working with clients and staff. When systems serve clients in manners that re-traumatize survivors, not only is harm done, but trauma continues to successfully hide in plain view. Finally, for systems to prevent undue harm to clients a trauma-informed care approach is foundational to begin healing.

Organizations Examined in this Guidebook

The following five organizations and their published work were examined to determine what themes were common and contributing to the structure of being trauma-informed. Each organization differed in their service context from: a women's centre for substance use, child-welfare, education system, community housing services, and counselling and healthcare. See Appendix 1 for additional details on each organization listed below and a link to their guidebook.

Jean Tweed Centre (JTC)
The Jean Tweed Centre provides a community-based, trauma-informed program in Toronto, Ontario for women dealing with substance use, mental health and gambling issues. The 'Trauma Matters' comprehensive trauma-informed guidebook provided on their website was examined. The guidebook offers examples of trauma-informed practice that JTC has implemented when working with women along with recommendations for other organizations to incorporate.

Chadwick Centre for Children and Families (CW)
The Chadwick Centre in San Diego focuses on child advocacy and trauma treatment in the realms of child and family abuse. The centre offers a trauma-informed guidebook called 'Guidelines to applying a trauma lens to a child welfare practice model' which was examined. CW's guidebook contains a compilation of literature and examples recommending how to transform a child welfare service into a trauma-informed practice.

Australian Childhood Foundation (ACF)
The Australian Childhood Foundation focuses on ensuring the safety of children who have experienced abuse, violence and neglect. Their 'Making SPACE for Learning' manual designed for informing schools to be trauma-informed was examined. The ACF's guide advocates different strategies for how a school can become trauma-informed with real-life examples from teachers who have implemented various techniques over the past five years.

Potrero Hill Community Building (PH)
Potrero Hill in San Francisco has been a lower-socioeconomic community with members suffering from many traumatic experiences over the years. In 2011 they created a 'Trauma Informed Community Building' (TICB) model developed to work with chronic health, safety issues, community violence, poverty, and structural racism. TICB provides examples of how the Potrero Hill community implemented trauma-informed strategies with community engagement and community housing initiatives.

Klinic – Manitoba Trauma Information & Education Centre (MTIEC)
Klinic is a toolkit developed in Manitoba by MTIEC to meet the unique needs of those who have been affected by trauma in counselling and health services. This toolkit provides education to practitioners and recommendations on how service providers and administration can shift their organization to become trauma-informed.

All-Encompassing Themes

The following eight themes have been identified within each of the five organizations examined. Each theme will include an elaboration on why it is an important factor in trauma-informed work. Following, each theme will include examples from the organizations examined, either from the direct service level (i.e., front-line work) or the organizational structure (i.e., policies and procedures) exemplifying what the theme looks like in practice.

The order of the principles does not denote order of importance, rather all the themes work in conjunction, vary in the degree of influence in both a direct and indirect manner, and are equally pertinent for becoming a trauma-informed practice..

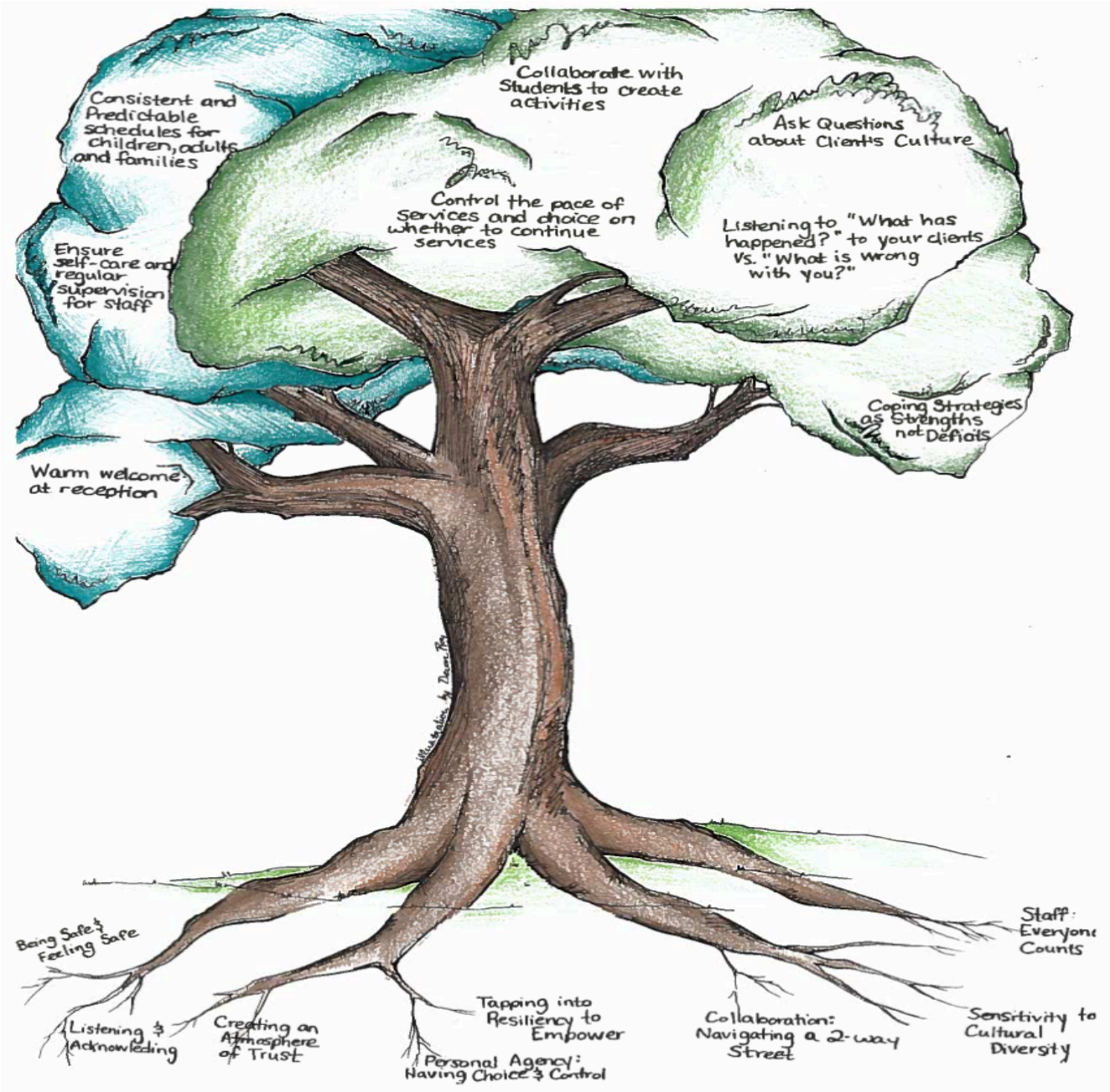
It is important to reiterate that there may be themes to be added, removed, or condensed as the process of becoming a trauma-informed practice is fluid and based on the context of your organization. Depending on the context of your service delivery, you may want to consider adding or removing themes that are suitable.

Finally, it is important to note that all themes should be considered when working with clients *and* staff. Staff is listed as a separate theme which will be elaborated further upon; however, each theme equally applies to staff insomuch that everyone matters. If everyone matters, we prevent staff turnover, burnout, and secondary trauma when working in strenuous environments.

Themes:

1. *Being Safe and Feeling Safe*
2. *Listening and Acknowledging*
3. *Creating an Atmosphere of Trust*
4. *Personal Agency: Having Choice and Control*
5. *Tapping into Resiliency to Empower*
6. *Collaboration: Navigating a 2-Way Street*
7. *Sensitivity in Cultural Diversity*
8. *Staff: Everyone Counts*

Framework


Consistent and Predictable schedules for children, adults and families
Collaborate with Students to create activities
Ask Questions about Clients Culture
Control the pace of services and choice on whether to continue services
Listening to "What has happened?" to your clients Vs. "What is wrong with you?"
Ensure self-care and regular supervision for staff
Coping Strategies as Strengths not Deficits
Warm welcome at reception
Being Safe & Feeling Safe
Listening & Acknowledging
Creating an Atmosphere of Trust
Tapping into Resiliency to Empower
Personal Agency: Having Choice & Control
Collaboration: Navigating a 2-way Street
Sensitivity to Cultural Diversity
Staff: Everyone Counts

1. Being Safe and Feeling Safe

Safety is a significant theme within each trauma-informed organization examined. Safety for both clients and staff is at the forefront of practice with each subsequent theme identified in this guidebook building upon safety.

What is Safety from a Trauma-Informed Perspective?

Safety is not solely ensuring physical safety, rather, it involves addressing both physical and emotional safety. It includes a physical sense of "being safe" as well as a psychological sense of "feeling safe." At all levels of practice, from an organizational level down to the direct service level, ensuring 'being' and 'feeling' safe for both staff and clients is a cornerstone of trauma-informed practice. Ultimately, safety is about avoiding and minimizing triggers that can create a re-traumatic response for individuals who have experienced trauma.

Individuals who have experienced trauma often have lived or are living through a relationship that feels unsafe due to an abuse of power towards them. Creating an atmosphere of physical safety can extend to what may seem like miniscule and trivial factors, but are of actual paramount importance. For example, the warmth of a room, wall color tones, reading materials in the waiting area, furniture arrangement of offices, and allowing a client to choose to sit where they feel safe, whether it be closer to a door or with their back against a wall all contribute to a physical sense of safety.

Furthermore, experiencing trauma can leave individuals stuck in the traumatic moments of time that are continuously re-lived creating persistent symptoms, reactions, and emotional dis-regulation in the present; for example, flashbacks from triggering topics, an inability to focus inward, dissociation, and outbursts of anger. With this knowledge, it is important to create an atmosphere of emotional safety when working with individuals experiencing these symptoms. Symptoms are understood in the context of trauma responses and not as personal attacks on the staff member. Therefore, listening and understanding what has happened to the person creates emotional safety allowing the client to not feel judged, shamed, or blamed for their behaviour.

Other factors that facilitate a physical and emotional sense of safety include, but are not limited to, positive relationship building, offering flexibility in services to meet a diversity of client needs, asking about cultural differences to understand needs, and asking for feedback around how a service is provided. Finally, staff safety around the potential of experiencing secondary trauma (experiencing the symptoms of trauma through indirectly interacting with those who have directly experienced trauma) is discussed in the "Staff: Everyone Counts" theme.
Below, we look at what the theme of 'being' and 'feeling' safe in practice looks like across the five trauma-informed organizations.

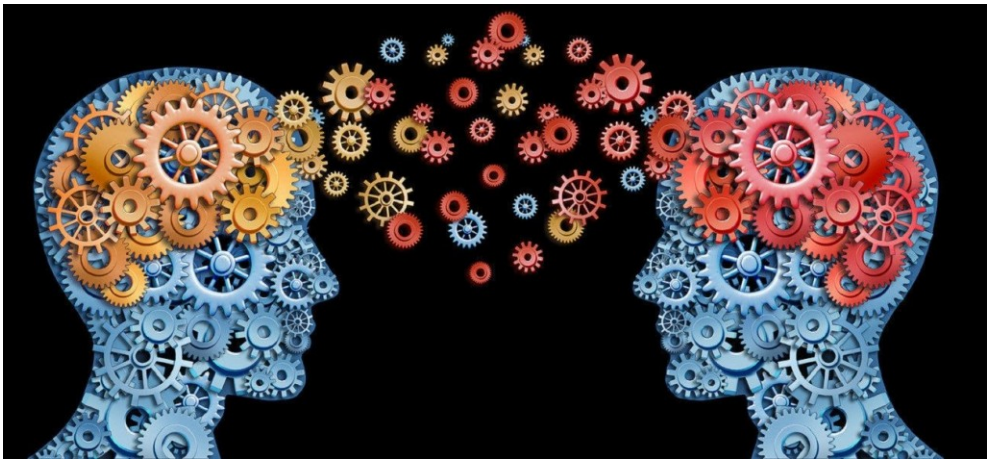
What does Safety look like in Practice?

Jean Tweed Centre	▫ At the JTC, creating safety is established through relationship building with female clients. ▫ A safety consideration that JTC considers is the need to prevent or reduce triggers in a co-ed centre where female clients may be triggered by male staff. Thus, safety is facilitated through informed consent and asking for client feedback regarding what they need to feel safe. Informed consent is ensuring clients are aware why questions are being asked of them and why certain techniques are to be used.
Chadwick Centre for Children and Families	▫ In child welfare practice, safety is the top priority when working in-home and out-of-home with children, family, and staff. ▫ CW recommends that safety plans are created in collaboration with children and families. Safety plans involve addressing emotional safety to bridge transition between removing children from home and placement within foster care. Emotional safety can be initiated by answering all the questions that the child may have during the process.
Australian Childhood Foundation	▫ ACF recommend teachers develop unique written lesson plans that cater toward students who have experienced trauma to create predictability and stability for a safe learning environment. These plans would be consistently utilized throughout the school by all staff who interact with students. ▫ Additionally, working with the student to identify safe areas or person(s) within the school can help regulate distressing emotions and further provide a sense of safety for the child.
Potrero Hill Community Building	▫ At PH, safety is created through a sense of connectedness where community members get to know one another through community activities. ▫ Consistent location and time of activities create predictability and consistency to foster a safe environment for community members. ▫ PH also implemented a 'Walking Bus' program which pairs staff and community members to walk each other to and from activities. This helps to facilitate a physical and emotional sense of safety.
Klinic	▫ In counselling and health services, Klinic emphasizes regulation and grounding techniques to ensure an individual is not re-living their past experiences. These strategies help clients feel connected and safe in the present moment. ▫ Safety is also emphasized by the timing and pacing of client inquiries. A full disclosure of trauma information may re-trigger a client and is avoided. Instead, the use of titration, a method to move the client forward at their own pace while respecting the need to slow down, fosters a sense of safety and control for the client.

2. Listening and Acknowledging

What are we Listening to and Acknowledging?

As we listen to and acknowledge the stories of those that have experienced trauma, we become aware and understand that trauma is widespread, pervasive, and affects a large portion of the individuals we interact with. Seventy-six percent of adults in Canada report some form of experience, and/or exposure to trauma in their lifetime (Van Amerigen, et al., 2008). Therefore, trauma can hide in plain sight if we do not take the time to listen.



When we listen, we hear the voices of how trauma can be at the core of an individual's development; we hear the sounds that echo through time after the trauma has passed where we see the relationship of trauma and its detrimental effects on present-day health. Listening allows us to understand the coping mechanisms and strategies that individuals have used to be able to regulate the harmful effects and survive the traumatic experience. If we can listen and understand, then we will be able to acknowledge and accept without judgement, blame, and shame. Therefore, it is about listening to how trauma lays its mark on an individual and what the resulting effects are. Understanding an individual's story will help to understand them in the present.

Acknowledgement of the experience of trauma means that it is imperative to meet clients where they are at in their healing journey. To allow clients to determine how and when they move forward is to accept that pushing an individual who has experienced trauma may re-trigger trauma reactions and propel them backwards. Such a negative experience may befall clients if service providers follow their own agenda rather than listening to what the client's agenda is. A core focus of listening is understanding triggers and triggered responses, and how to respond appropriately.

What does Listening and Acknowledging look like in Practice?

Jean Tweed Centre	▫ At the JTC, listening and acknowledgement is demonstrated by staff understanding the interrelationship of addictions with trauma. For many clients, the experience of trauma is the underlying issue beneath addictions. Therefore, staff work with clients to reduce addictions and are vigilant to noticing symptoms of trauma that may appear subsequent to treatment. Staff and clients work to develop harm reduction strategies for addictions and management techniques for the symptoms of trauma. ▫ Acknowledgement at JTC is also exemplified through identifying their own limitations. If JTC's resources may not be suitable for a particular client, additional resources and contacts are offered to meet client needs.
Chadwick Centre for Children and Families	▫ CW recommend service providers to listen to the trauma that children and families in the system have experienced and acknowledges that they may have been disserviced in the past. For example, when social services removes children from their homes, blame has often bestowed upon parents rather than working collaboratively to understand their extensive trauma histories. CW emphasizes it is important to listen to and understand how adult trauma can interfere with the adult's capacity to care and support children. CW strives for child welfare organizations to shift from blame to understanding.
Australian Childhood Foundation	▫ To understand the unique needs of children who have experienced trauma, ACF recommends teachers and staff to be educated on attachment styles, child development, and the neurobiology of trauma. In practice, teachers developed teaching tools that are specific to trauma reactions of a student. ▫ An example of listening to and acknowledging is demonstrated by considering the benefit of a student being placed in a different classroom than the norm on days with a substitute teacher. The different classroom would have a familiar teacher which the student has a secure and safe attachment to.
Potrero Hill Community Building	▫ PH demonstrates listening through understanding that some community members participate in activities for self-growth, healing, building safe connections, or just to receive incentive gift cards at the completion of an activity. Regardless of what community members are looking for, PH meet these individuals at the various points of their healing journey.
Klinic	▫ The Klinic toolkit recommend that practitioners demonstrate an understanding toward a client's trauma symptoms as survival responses to traumatic experiences that were outside of the client's control. ▫ Additionally, Klinic suggests listening through the process of universal screening which is a methodology that includes questions surrounding trauma histories to understand where the client has come from and what has happened to them. Universal screening includes informed consent by explaining the purpose of screening for trauma and how this information can be helpful.

3. Creating an Atmosphere of Trust

Many individuals who have experienced trauma have often been engaged in or are currently in abusive relationships where boundaries have been blurred, inconsistent, and crossed. This can lead to holding feelings of untrustworthiness and a fear for one's safety when it comes to interacting with others in the future. One of the key aspects of a trauma-informed organization is not only to provide a sense of safety, but to continually build and foster a trusting relationship.

Organizations have a responsibility to uphold honesty and respect when working with clients and staff. This includes understanding that time, patience, respect and honesty are required to establish a trusting relationship.

Creating an atmosphere of trust can be developed through including a transparent process of service delivery. This can involve an elaboration on tasks, upholding consistent and predictable expectations, and establishing and modelling clear and healthy boundaries for clients.

Furthermore, responsibility falls upon organizations to maintain trusting relationships by outlining any limitations of caregiving. When an organization is not equipped with the resources to support an individual (e.g., if a client or staff needs trauma-specific counselling), then the organization takes the responsibility to ensure the client is properly connected with the appropriate resources.

Finally, trust can be developed by recognizing the power of language. From written material to verbal interactions, language that avoids stigmatization, labeling, shame, and blame can demonstrate and create an atmosphere of safety and trust when working with clients.

What does Building Trust Look Like?

Jean Tweed Centre	▫ JTC emphasizes practitioners to be conscious of body language, facial expressions, and emotional congruence where neutral and non-threatening body language can foster a sense of trust and safety. In contrast, aggressive and frustrated body language may be triggering for clients. ▫ Moreover, JTC demonstrates responsibility by following commitments once they are set out. The organization commits to responding to phone calls and client inquiries as initially communicated.
Chadwick Centre for Children and Families	▫ CW recommends a continual evaluation of practice and outcomes with the focus on maintaining consistency in the delivery of programs and services. Ensuring appropriate funding and resources are allocated to social programs creates consistency and predictability for clients. ▫ Consistency and predictability is also emphasized by scheduling appointments with clients that are convenient for their schedule which can build a sense of trust.
Australian Childhood Foundation	▫ ACF recommends that trust within school systems is built through safe, predictable, and consistent schedules for students. ▫ ACF emphasizes that adult connection allows for a safe relationship to model behaviour, help children regulate, and foster a productive learning environment. Teachers can set up one-on-one time with children to listen, talk and/or draw which facilitates both relationship and trust building. ▫ Furthermore, ACF emphasizes that consistency fosters trust between teachers and students. This is demonstrated by consistent behavior toward students in a variety of settings. For example, consistent warmth in responses during supervision at recess and in the classroom.
Potrero Hill Community Building	▫ PH fosters trust through hiring a member of the community which allows for a familiar face to increase community engagement. This employee is called a 'Junior Community Builder' where they act as a gatekeeper, an advocate, an outreach worker, role model and activity leader. ▫ PH also develops trust by ensuring consistency in the long-term sustainability of programs and activities. To create sustainability of the program, funding needs to be consistent, otherwise, an atmosphere of distrust can arise in the community.
Klinic	▫ Klinic advises to create a trauma-informed committee to ensure responsibility, trust, honesty and respect are upheld. The committee would review policies and procedures in place to ensure sensitivity and respect toward clients is being adhered to at all service levels. ▫ Klinic also emphasizes regular staff meetings and staff check-ins to focus on educating staff about the informed consent process, confidentiality, keeping clear and consistent boundaries, and ensuring that honesty and transparency is embedded within the work.

4. Personal Agency: Having Choice and Control

Why Personal Agency?

Personal agency refers to an individual having the volition to act in a given situation that is their choice. Individuals who have experienced trauma have often unwillingly forfeited this volition in which they have lost their power, choice, and control in a particular situation (e.g., abuse towards them, a natural disaster, etc.).

Providing a choice and a sense of control for staff and clients inherently creates safety and trust. Additionally, the ability to exert one's choice and control empowers the individual who has experienced a restriction of choice in the past.

This means organizations provide choice and control whenever and wherever possible. For example, a choice of what services are received, level of participation, how quick the process ensues, and a choice to withdraw at any time. Choice and control should also extend to including clients in evaluative methods of service so that the voices of clients are heard and incorporated.

How is Choice and Control Demonstrated?

Jean Tweed Centre	▫ JTC demonstrates choice and control by letting clients choose how to be contacted, whether to leave a message, and how service continues or terminates based on where the client is at. ▫ JTC also offers choices to clients based on the stage of recovery that the client is in. If clients are not ready to eliminate substance use, meeting them there by offering choices available at this stage of recovery demonstrates a sense of control for clients. ▫ Additionally, a search of belonging is a regular process with clients. Clients are informed about the search and given a choice to engage in the process.
Chadwick Centre for Children and Families	▫ In child protection, interviewing children is common. CW recommends that while interviewing, staff are able to provide time and space before and after the interview to allow for informed consent and emotional de-escalation which can assist the child in feeling in control. ▫ Furthermore, CW emphasizes that during in-home visits providing parents with information that they can utilize to obtain trauma-informed services allows for a sense of choice and control on what and when to access additional services.
Australian Childhood Foundation	▫ ACF suggests creating spaces for students in classrooms to physically move to (such as open corners within the room) allows them to use strategies to facilitate emotional regulation and soothing while still being engaged in class to create a sense of control in their environment. ▫ Additionally, ACF emphasizes control and predictability by allowing children to choose their own activities within a set structure throughout the day and discussing where and when these activities will happen.
Potrero Hill Community Building	▫ At PH, staff provides incentive gift cards for involvement in community activities (such as public house building and gardening). The participants have choice and control over what activities they choose to engage in, while having the ability to choose when and what they spend the gift card on. ▫ Further, during activities at PH a mutual sharing of experiences is encouraged, however, community participants have a choice whether they feel comfortable in sharing their experiences.
Klinic	▫ Klinic emphasizes to foster choice and control during intake interviews, clients are provided with a choice whether they want to answer particular questions and how much information they feel comfortable to disclose. ▫ Klinic also suggests that when working with clients a sense of choice and control is demonstrated by following the path the client feels is suitable for their healing needs and what this comprises of. ▫ Additionally, fostering a sense of control is also recommended by allowing clients to know what, and where their file is held, the contents within their file, and access to it at any time.

5. Tapping into Resiliency to Empower

How is Focusing on Empowerment and Resiliency Trauma-Informed?

Systems can be too encumbered by focusing on clients' deficits rather than their strengths. Instead of focusing on pathology, strength-based practice focuses on the resilience that clients exhibit and emphasize empowerment within practice. Key to following this practice is instilling hope, optimism, and promoting resilience; therefore, a client can utilize their strengths, feel self-efficacious and in turn feel more in control of their situation. Focusing on capacity, rather than deficits is a key proponent in building trust and a professional working relationship.

Upon exploring the client's past, a trauma-informed approach emphasizes, captures, highlights, and celebrates resiliency that a client has utilized to cope until now. An example of zoning in on resiliency would be focusing on a client's courage to reach out for services.

Empowering staff and clients allows for a sense of personal agency and affords the individual the ability to take the tools learned and apply it within their own lives. Empowerment can be created by teaching and modelling skills for recognizing triggers, calming strategies, emotional regulatory techniques, and communication skills. Dr. Sandra Bloom in her 'Sanctuary Model,' (Bloom & Yanosy-Sreedhar, 2008) which addresses trauma-informed organizational change, refers to these empowerment strategies as an organizational culture represented by 'emotional intelligence' and 'social learning.'

How do we Tap into Resiliency?

Jean Tweed Centre	▫ JTC emphasizes increasing a women's self-knowledge to empower her to choose what works for her situation. Self-knowledge is developed by learning healthy boundaries, assertiveness skills, and building self-esteem. ▫ JTC educates women that the reduction of substance use can lead to an increase in trauma reactions. Education on this phenomenon is provided in hopes to empower and prevent feelings of failure when aversive symptoms of trauma come to the surface after reduced substance use.
Chadwick Centre for Children and Families	▫ CW recommends that shifting language within child welfare practice can empower families rather than put-down families because historically, parents were vilified and children were considered the victims. ▫ CW emphasizes a strength-based focus by including the parents as part of the solution rather than the problem in the decision-making processes. This is achieved by providing parents with education and tools regarding trauma reactions and understanding how to manage their child's reactions. ▫ Additionally, CW suggest that reframing children's behaviour 'problems' to survival responses in reaction to a traumatic experience can provide children with a sense of empowerment in their situations.
Australian Childhood Foundation	▫ The ACF recommends that in school programs, focusing on a child's interests to create activities and allowing that child to lead and invite other children to participate creates a sense of empowerment. ▫ Teachers used visual web activities to identify and explore children's strengths and their support systems. ▫ Additionally, teachers can help facilitate children to find identities that feel suitable, congruent, empowering, and hopeful to better understand their past experiences.
Potrero Hill Community Building	▫ PH demonstrates empowerment of community members through inclusiveness, equal participation, and accountability which provides a sense of ownership over decision-making and the change process. ▫ Community empowerment at PH is also fostered by having community leaders create activities from their previous successes. ▫ PH recognizes that community activities build safe relationships. However, when staff provides incentive gift cards at the end of activities, it empowers community members to feel accomplished and self-efficacious.
Klinic	▫ Klinic emphasizes the acknowledgement of the client's strength, tenacity, and resilience it took to get where the client is currently. (i.e. resilience to make it to their scheduled appointment). ▫ Moreover, Klinic suggests that empowerment can also come from reframing behavioural trauma reactions as survival responses in which a client adapts to their environment.

6. Collaboration: Navigating a 2-Way Street

What about Collaboration?

Collaboration is two-fold, collaboration with clients and collaboration amongst service providers. What is important to understand is the recognition of an inherent power imbalance between service providers and clients. Service providers may have the knowledge, tools, and skills that clients may or may not have yet, thus, trying to ameliorate this imbalance in any way possible.

Understanding that clients had relational ties in the past that have been broken, one-sided, and detrimental to their well-being requires patience and compassion in building a trusting relationship. Working in conjunction with clients, following their lead and what pathways work for them is a way to contribute to collaboration, trustworthiness, and safety. Collaboration reduces power imbalances and fosters safety for building a positive relationship. Collaboration allows for a sense of choice and control when decision-making processes are equal rather than services acting as if they know what is in the best interest for clients.

Furthermore, collaboration with clients ensures client voices are heard. Hearing their voice in decision-making processes and in feedback about service delivery can empower clients.

Finally, collaboration between organizations is imperative to ensure that the trauma-informed work from one organization is not undone by another organization that is not yet trauma-informed. Communication and collaboration between service providers ensures proper care for clients is engaged in across service contexts.

Collaboration in Practice

Jean Tweed Centre	▫ JTC demonstrates collaboration with clients through flexibility in which changes are made to ensure that there are appropriate accommodations made for clients who have experienced trauma. For example, listening to, talking about, and being flexible to adjust around addressing a woman's discomfort with the set-up of a physical space. ▫ Additionally, at JTC, women are offered choices as the service delivery ensues and can co-manage the pacing of their healing experiences which creates a sense of collaboration.
Chadwick Centre for Children and Families	▫ CW notices that the child welfare system interacts with many partners in the child-care process including law enforcement, attorneys and schools. CW recommends that training, consistency in language, shared information forms, and communication at all levels is undertaken so that a collaborative effort can be ensured when working with clients who have experienced trauma. For example, services providers share information amongst each other with client consent to reduce the number of intake interviews and prevent re-traumatization for children. This further demonstrates an organization's commitment of collaboration. ▫ When creating out-of-home safety plans, CW emphasizes the inclusion of parental input, resources, strengths and feedback at all steps of planning to foster a sense of collaboration.
Australian Childhood Foundation	▫ At ACF, teachers demonstrate collaboration through involving students in creating, maintaining and upholding classroom rules that feel suitable and comfortable for everyone. ▫ Furthermore, teachers demonstrate collaboration with parents by understanding and responding to the needs of specific students through identifying triggers, triggered responses, and behavioural patterns.
Potrero Hill Community Building	▫ PH recognizes that residents interact with a wide array of service providers (e.g., health, education, law enforcement) which may not understand the unique needs of community members. PH demonstrate collaboration amongst community organizations through the program called the 'Walking Club' (members walking each other to and from appointments) where education is provided to the varying services interacted with surrounding the unique needs of those who have experienced trauma. ▫ PH also emphasizes inclusiveness by ensuring residents are involved in decision-making processes. Community members who have historically experienced inequality can now choose which services to participate in.
Klinic	▫ Klinic recommends allowing clients to set the pace of service delivery and make choices regarding treatment plans to foster a sense of collaboration. ▫ Additionally, Klinic suggests that service providers can benefit by avidly seeking feedback to see what is working and what is not and maintaining transparency which fosters collaboration, trust, and safety with clients.

7. Sensitivity to Cultural Diversity

Why is Cultural Sensitivity Part of Trauma-Informed?

The diversity of people and their culture includes a wide variety of issues such as, but not limited to, gender, age, language, socio-economic status, race, and sexual orientation. As individuals come from differing backgrounds, there are differences between cultures, but also drastic differences within cultures. Utilizing a trauma-informed lens with culture means that trauma and the experience of trauma may mean different things to different people. Traumatic experiences may be presented differently, and responding to trauma may be handled differently within varying cultures. Therefore, it is important for service providers to ensure that working with clients is done with an open-mind to exploring and learning about how trauma may differ.

Having a sensitivity toward culture within the workforce means that at all levels within an organization, respect toward varying cultures is upheld. Service providers are not expected to become experts in every culture, rather, time is invested to acknowledge and educate on cultural difference to respect cultural diversity.

What does Cultural Sensitivity Look Like in Practice?

Jean Tweed Centre	▫ At JTC, it is emphasized that each woman is the 'expert' on her life and it is the staff's responsibility to learn about her cultural differences. For example, residential bed checks are administered regularly and for some cultures, it is not acceptable for a man to enter a woman's bedroom. Having this understanding and awareness can prevent triggers and re-traumatization while simultaneously holding respect for the client's culture when considering conducting a bed check.
Chadwick Centre for Children and Families	▫ CW recommends that prior to in-home placements staff, foster parents, and birth parents meet to discuss expectations, routines, and how to collaboratively care for the child to learn about any cultural differences.
Australian Childhood Foundation	▫ ACF emphasizes that within the school system, acknowledging the reality of one's bias is imperative where teachers may hold an ethnocentric viewpoint where 'culture' is seen only for others. Through acknowledgement, teachers can understand how their culture influences their interactions within a diverse cultural classroom and adjust accordingly to include culturally sensitive practices.
Potrero Hill Community Building	▫ At PH, cultural sensitivity is demonstrated by hiring staff in community programs who represent diverse backgrounds to increase inclusion, familiarity, participation, and safety for other members to join. ▫ Another strategy is to ensure cultural sensitivity though inclusive and sensitive language. PH prints materials in a wide array of languages to ensure that all residents feel included to participate in community activities.
Klinic	▫ The Klinic toolkit emphasizes the im3portance of understanding what the definition of 'healing' means to each client and their cultural context. This can be achieved by asking clients questions about their culture, referring clients to services suitable for their cultural needs, and considering that western healing practices may not be suitable for all clients.

8. Staff: Everyone Counts

Why is 'Staff' a Separate Category?

As noted before, staff within organizations should be considered with all the aforementioned themes of trauma-informed practice. However, staff are included here for two reasons: [1] for ensuring staff competencies and training in becoming trauma-informed, and [2] for ensuring that trauma-informed principles are also applied to staff to recognize and prevent secondary trauma.

Staff at all agencies, whether working on the front-line or behind the scenes may come into contact with clients. When contact occurs, if staff are unaware of potential triggers or effects of trauma, there may be an inadvertent triggering of clients. Organizational culture, policy, and procedures should foster staff education, training, values, attitude, and skill building surrounding trauma-informed practices. Therefore, staff will be able to understand the effects of trauma and effectively utilize themes outlined in this guide.

Moreover, practices often focus on enhancing quality for clients but fail to procure the same amount of care to staff. High-stress jobs result in higher turnover rates and burned out staff. Being trauma-informed means it is imperative to consider the well-being and ensure proper self-care for staff is considered.

Thus, it falls upon organizations to ensure that staff are cared for where managers monitor caseloads, offer self-care, allow for personal days, provide regular supervision, and teach skill building to support the well-being of staff. As a result, staff will avoid the potential of becoming secondarily traumatized and services can continually be provided to clients at full capacity. Secondary trauma is the experience of trauma symptoms such as sadness, depression, anxiety, and sleep disturbances by witnessing another's traumatic story without directly experiencing the traumatic event itself (Conrad & Keller-Guenther, 2006).

Working with Staff

Jean Tweed Centre	▫ At JTC, ensuring staff competencies is demonstrated through hiring processes including interview questions around self-care strategies and trauma knowledge. Staff then receive education and training to further trauma-sensitive practices and receive regular clinical supervision in which staff are encourage to debrief tough cases and discuss self-care strategies with their supervisors.
Chadwick Centre for Children and Families	▫ CW recommends that prior-briefing and post-debriefing is offered to staff to provide emotional support when going through a difficult appointment such as removing a child from their home. In debriefing, supervisors are encouraged to discuss strategies that can ease the distress of removal and what role the staff can play to reduce overall stress and enhance safety for all individuals included. ▫ CW also emphasizes that staff are offered regular supervision with supervisors where staff can discuss the impacts of work and process various feelings and reactions to workplace stress. ▫ Additionally, CW suggests that training for staff focuses on learning how to identify signs of secondary trauma and self-care strategies to ensure well-being when working in emotionally difficult situations.
Australian Childhood Foundation	▫ The ACF recommends that professional development workshops are offered to schools to discuss the neurobiology of trauma, stress, and how this can play out in a child's life to better meet children's needs. ▫ Additionally, ACF emphasizes training offered to both administrative and support staff should be consistent with teachers to provide predictable interactions to students who have experienced trauma.
Potrero Hill Community Building	▫ At PH, the 'Junior Community Builder' holds dual responsibilities where they work for the community programs and are community leaders engaged in decision-making. Staff care is demonstrated by supervisors who recognize the demand of this role and subsequently providing intense management, training, debriefing and emotional support to prevent the risk of secondary trauma and burnout.
Klinic	▫ Klinic recommends that job descriptions for hiring staff outline a requirement for staff to have the skills and knowledge for working with people who have experienced trauma to ensure staff competency within the organization. ▫ Klinic also advises that staff are released from their usual duties to receive trauma training to gain the knowledge on how to serve clients appropriately.

Conclusion

The goal of trauma-informed care is to provide services in a safe and non-retraumatizing manner to individuals who have experienced trauma. Becoming trauma-informed does not mean an organization needs to treat a client's trauma symptoms but rather be considerate, respectful, and caring when engaging with clients.

My guidebook outlines eight common, trauma-informed themes that have been adopted in the service contexts of a women's centre for substance use, child-welfare, education system, community housing services, and counselling and healthcare. Therefore, trauma-informed practice can be implemented across diverse settings to work with staff or clients who have experienced trauma. This guidebook is intended to be used as a starting point in understanding themes and transforming an organization to become trauma-informed. A step-by-step process is beyond the scope of this project. Appendix 1 provides more details regarding the five organizations used as examples and a link to their guidebook for more information on their implementation of trauma-informed practice. Furthermore, Appendix 2 provides additional resources on guidebooks and guidelines on how to become trauma-informed in settings that work with child, youth, family, addictions and mental health.

Appendix 1: Organizations Examined in this Guidebook

Jean Tweed Centre

The Jean Tweed Centre was established in 1983 and named after Jean Shannon Tweed who provided a safe and facilitative environment for women dealing with their substance use issues. Services offered at the centre include individual counselling, group counselling, support groups, educational groups, residential and day programs, outreach mental health, addictions and parent services, and pregnancy services.

Where to access:

'Trauma Matters', a comprehensive trauma-informed guidebook is provided on their website:

http://jeantweed.com/wp-content/themes/JTC/pdfs/Trauma Matters online version August 2013.pdf

Chadwick Centre for Children and Families

The Chadwick Centre in San Diego works with treating trauma from child and family abuse. Created by Dr. David Chadwick in 1976 the centre focuses on child protection and child advocacy. The centre offers a multidisciplinary approach to intervention, healing and family support through programs such as: forensic medical exams and support, out-patient pediatric support, court education services, trauma-counselling services, and individual and family therapy.

Where to access:

'Guidelines to applying a trauma lens to a child welfare practice model' is provided on their website:

https://ctisp.org/trauma-informed-child-welfare-practice-toolkit/

Australian Childhood Foundation

The Australian Childhood Foundation, centered in Australia focuses on saving children who have experienced abuse, neglect, and family violence. Programs offered through the foundation include trauma recovery services, safe havens through trauma recovery healing centres, child protection services, and education and training for professionals working with children. Part of ACF's curriculum includes educating teachers in working with children in schools who have experienced trauma.

Where to access:

The 'Making SPACE for Learning' manual designed for informing schools to be trauma-informed is linked below:

http://www.childhood.org.au/search-results?keywords=Making%20SPACE%20for%20Learning%20

Appendix 1: Organizations Examined in this Guidebook (Continued)

Potrero Hill Community Building

Potrero Hill developed in 1941 in San Francisco has been a community who has suffered from poverty and aversive events. In 2011 they created a 'Trauma Informed Community Building (TICB)' model developed to work with chronic health, safety issues, community violence, poverty, and structural racism. This model focuses on a community re-development housing initiative to improve residents living spaces and overall well-being. Community involvement ensures individual's voices to be heard and involved. Thus, TICB aims to facilitate community housing while considering community healing as part of the process.

Where to access:

2-part manual, the first manual provides the outline of their model and the second an evaluation of the TICB model.

http://bridgehousing.com/PDFs/TICB.Paper5.14.pdf

https://healthequity.sfsu.edu/sites/default/files/TICB_Evaluation_Report_10.16.pdf

KLINIC – Manitoba Trauma Information & Education Centre

The Manitoba Trauma Information and Education Centre (MTIEC) established in 2011 is an organization based out of Winnipeg, Manitoba. MTIEC offers a wide array of services from medical care, counselling, crisis services and education. MTIEC developed a trauma informed toolkit called KLINIC to guide their practice and for other organizations to utilize the tool to become trauma-informed in health care and social service settings. Their guide provides education on trauma, the effects and neurobiology of trauma, PTSD, types of trauma, residential school legacy, and how to integrate trauma-informed practices into organizations.

Where to access:

http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

Appendix 2: Trauma-Informed Resources

Children, Youth & Family Trauma-Informed Resources

Child Trauma Academy (CTA): CTA is a not-for-profit organization dedicated to working with high-risk children through direct service, research, and education. Free online learning modules and education are offered.

Website: http://childtrauma.org

Children's Mental Health Ontario (CMHO): A publicly funded organization focuses on the mental health of children, youth, and families. The CMHO website offers resources, education, and links for youth, parents, practitioners, and teachers.

Website: http://cmho.org

National Child Traumatic Stress Network (NCTSN): NCTSN focuses on providing information and links regarding education, care, treatment, and services to children and adolescents who have experienced trauma.

Website: http://www.nctsnet.org

The Trauma Centre: Training, courses, and education offered to mental health professionals with a trauma-lens focus. Founded by one of the leading psychologists in the field of psychological trauma: Dr. Bessel van der Kolk.

Website: http://www.traumacenter.org

Trauma Informed Care Project: Focusing on education resources for the impact of trauma and its consequences on the community. Resources, guidebooks, and articles are provided on trauma-informed practice.

Website: http://www.traumainformedcareproject.org/index.php

Trauma-Informed Organizational Toolkit for Homeless Services: The American Institutes for Research (AIR) provides a trauma-informed toolkit for working with displaced children and families and how to implement trauma-informed practices with homelessness services.

Website: http://www.air.org/center/national-center-family-homelessness

Appendix 2: Trauma-Informed Resources (Continued)

Addictions and Mental Health Trauma-Informed Resources

Bridging Responses: A Front-Line worker's guide to supporting women who have post-traumatic stress: A PDF workbook for service sectors working with women and trauma experiences, recognizing triggers and responses, and information on how to inquire about trauma issues.

Website: http://www.camhx.ca/Publications/Resources_for_Professionals/Bridging_responses/bridging_responses.pdf

Oregon Health Services – Trauma Informed and Trauma Specific Services: Screening tools, presentations, and crisis contact information for a trauma-informed approach to work with addictions and mental health.

Website: http://www.oregon.gov/oha/amh/pages/trauma.aspx

Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHSA offers training for consumers and staff from a trauma-informed lens. Referral supports, crisis lines, and support services are offered.

Website: https://www.samhsa.gov/nctic

Resource Guides

Trauma-Informed Practice Guide: A 93-page trauma-informed guide [PDF] created by the BC Provincial Mental Health and Substance Use Planning Council. The guide is intended for organizations to consult with in adopting a trauma-informed lens, include is an organizational checklist for becoming trauma-informed along with case examples and step-by-step strategies.

Website: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Residential Substance Abuse Treatment guide (RSAT): A 89-page guide providing knowledge and awareness of the interplay between substance abuse and trauma in correctional settings. Additionally, the guide offers suggestions to implement trauma informed practice in correctional settings.

Website: http://www.rsat-tta.com/Files/Trainings/Trauma_Informed_Manual

References

Bloom, S.L. & Yanosy-Sreedhar, S. (2008). The Sanctuary Model of trauma-informed organizational change. *Reclaiming Children & Youth*, *17*(3), 48-53.

Conrad, D. & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect, 30*, 1071-1080. doi:10.1016/j.chiabu.2006.03.009

Fairchild, M. (2010). Resiliency article photo [Online image]. Retrieved March 23, 2017 from http://cosmiccowgirlsmagazine.com/2010/12/

Goodman, L., A., Dutton, M., A., & Harris, M. (1997). The relationship between violence dimensions and symptom severity among homeless, mentally ill women. *Journal of Traumatic Stress*, *10,* 51–70.

Harris, M., & Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New directions for Mental Health Services, 89*, 3-22.

Henkel, D. (2016). Trust [Online image]. Retrieved March 23, 2017 from http://www.afraidtoask.com/tag/understanding/

Kay. (2016). Globe holding [Online image]. Retrieved March 23, 2017 from http://globalforceforhealing.org/beyond-red-blue-you-are-my-favorite-color/

Mitchelle, W. (2016). Tree hands colored [Online image]. Retrieved March 23, 2017 from https://clipartfest.com/download/60cfded9b6967449452af0f1e5527f55eec255fb.html

Rules of friendship – Understanding [Online image]. (2013). Retrieved March 23, 2017 from http://www.danielehenkel.com/2016/05/trust-a-rare-asset/

STILLFX. (n.d.). Team of paper doll people [Online image]. Retrieved March 23, 2017 from https://www.shutterstock.com/image-photo/team-paper-doll-people-holding-hands-144653342?src=5L3BYKyvXmP8OWglg6AeuA-1-3

Van Ameringen, M., Mancini, C., Patterson, B., & Boyle, M. H. (2008). Post-traumatic stress disorder in Canada. *CNS Neuroscience & Therapeutics, 14*(3), 171-181.

Van der Kolk, B. A. (2015). *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. Penguin Group, New York, NY.

References (Continued)

Wolf, M. R., Green, S. A., Nochajski, T. H., Mendel, W. E., & Kusmaul, N. S. (2013). 'We're civil servants': The status of trauma-informed care in the community. *Journal of Social Service Research, 40*, 111-120. DOI: 10.1080/01488376.2013.845131

[Untitled illustration of a sign]. Retrieved March 23, 2017 from http://creativeeducator.tech4learning.com/2015/connections/give-students-choices

[Untitled illustration of two hands holding a tree]. Retrieved March 23, 2017 from http://www.huffingtonpost.com/natural-capital-coalition-/collaboration-the-art-of_b_10045646.html