CARING SAFELY

Trauma-Informed Practice

Level One

Instructor:

Charlene Richard, B.S.W., M.S.W., RSW

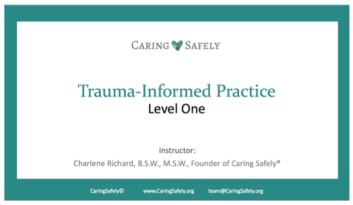
Founder of Caring Safely®

Instructor

Charlene Richard, B.S.W., M.S.W., RSW

- Clinical Social Worker (addictions and mental health)
- Educator – University of Calgary, Faculty of Social Work. Trauma informed practice subject matter expert
- Founder of Caring Safely® education and training for individuals and organizations on trauma informed compassion fatigue resiliency at www.CaringSafely.org or email: team@caringsafely.org

Workshop Materials



Access the resources reviewed during this workshop:
https://programs.caringsafely.org/log-in-page

Handouts

Resources

Learning Objectives

- ✓ Experience trauma-informed educational practices
- ✓ Explain what Adverse Childhood Experiences are and the impact they have on long-term health and social issues
- ✓ Screen for signs of Adverse Childhood Experiences as well as protective factors
- ✓ Summarize the difference between trauma-informed services and trauma-specific services
- ✓ Utilize a trauma-informed practice approach in you work

Trauma Informed Education Practices

- Over 70% of the population has experienced one or more traumatic events in their life
- As you will learn in the course, taking a trauma-informed approach means approaching each person with the understanding that it's possible they have experience one or more traumatic events, and that these events may impact their current health, behaviors and/or coping strategies in ways we can't see. We take that same approach with each learner as part of trauma-informed educational practices.

Safe Learning Environment

- While this workshop does discuss trauma, it will not include graphic details of trauma.
- Part of my role as a facilitator is to ensure a safe learning environment, which includes limiting your exposure to graphic details of trauma. If someone is participating in a discussion and I feel they may begin to disclose details of trauma, I will engage and review these safe learning environment guidelines.
- You will not be asked to share any details of your own history with trauma or ACE(s).
- Gentle reminder that this is an educational workshop for helping professionals and not a therapeutic intervention.

Learner Self-Care Plan

- This training is going to discuss various forms of trauma, the prevalence of trauma as well as the short-term and long-term impacts of trauma.
- Helping professionals (including those in attendance) may also have a history of trauma or Adverse Childhood Experiences.
- **Safety First:** If you feel yourself reacting to the material we are discussing, what will you do to take care of yourself?
  - Take a break and come back
  - Deep breathing, stretching, water, (self-soothing)
  - Contact someone who is a support

Workshop Participants

1) What field are you in?

2) How long have you been in your field or another helping role?

3) Have you taken a training on trauma-informed practice before?

Applied Learning – Case Study

- Throughout this workshop, you will be invited to apply your learnings through reflective exercises
- We will review a case study that will be used throughout the workshop that you can use for reflective exercises
- You are welcome to use your own case study as this will not be shared with anyone

Trauma

- A traumatic event can be a single experience or repeated/multiple experiences
- These experiences are completely overwhelming for the individual
- The individual was unprepared
- These experiences are beyond the person's control – there was nothing they could do to stop it from happening.
- They impact a person's ability to cope or integrate the thoughts and feelings experienced during the event.
- During these events the sympathetic branch of a person's nervous system is triggered, also known as the fight/flight or freeze response.

Types of Trauma

Single episode: One time traumatic experience. With support, most people can cope and recover without developing Post-Traumatic Stress Disorder.

Complex Trauma: Repeatedly experiencing trauma and results in chronic toxic stress, such as; family violence, abusive relationships, severe bullying, large scale violence (war, genocide).

Developmental Trauma: Repeated experiences of trauma (as infants, children and youth) involving neglect, abandonment, physical abuse or assault, sexual abuse or assault, emotional abuse, witnessing violence or death, and/or coercion or betrayal. (ACEs)

Types of Trauma

Intergenerational Trauma: The impact of trauma experienced by parents/caregivers on their children. Unhealthy behaviors, communication and maladaptive coping strategies can be modelled.

Historical trauma: The impact of trauma inflicted on a massive population by a dominant group such as: genocide, colonialism (for example, residential schools), slavery and war, that leads to cumulative emotional and psychological injuries over the lifespan and through generations.

Vicarious Trauma: The impact of exposure to the trauma of other individuals such as helping professionals and first responders. Can lead to acute stress or post traumatic stress disorder.

Acute Stress Disorder DSM5

A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred others.
3. Learning that the events occurred to a close family member or close friend. Note: In cases of actual or threated death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse). *Does not apply to exposure through electronic media, television, movies or pictures, unless this exposure is work related.*

Symptoms: Intrusion, Mood, Dissociation, Avoidance, Arousal – beginning or worsening after the event(s) occurred.

(American Psychiatric Association, 2013)

Arousal/Avoidance

Anxiety Depression

Arousal	Avoidance
Fear/Anxiety/Irritability	Depression/Hopelessness
Sleep disturbances, Appetite changes	Procrastination/Dread/Isolation
Impulsive/Compulsive Behavior	Blame/Relational Problems
Poor concentration/Obsessive thoughts	Less Self-Care
Immune problems	Rumination

Trauma-Informed Practice (Level Two) Reviews Strategies to Help

Post Traumatic Stress Disorder DSM5

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnesses, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threated death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse). *Does not apply to exposure through electronic media, television, movies or pictures, unless this exposure is work related.*

(American Psychiatric Association, 2013)

Acute Stress Vs. PTSD

- Acute stress disorder includes symptoms that begin after the traumatic event.
- Many people have resilience and coping skills that lead to recovery of the acute stress within four weeks of the traumatic experience.
- Post Traumatic Stress Disorder is a diagnosis that comes with longer terms symptoms of the event (4 weeks or longer).
- Post Traumatic Stress Disorder has more comprehensive subtypes of symptoms.

Prevalence of Trauma

- 76% percent of Canadians have experience one or more traumatic events.

(Van Ameringen, M., et al., 2008)

- 89.9 % of people in US have experience on or more traumatic events.
- Higher prevalence in women

(Kilpatrick et al. ,2013)

- ACE(s) – almost two thirds of people have had one or more adverse childhood experience.

(Burke Harris, N., 2018)

It is more likely than not that the people you are helping have experienced one or more traumatic events.

The Stress Response

- The Stress Response is also known as the Fight or Flight (or freeze) response.
- Brain perceives threat and stress response is activated to help us survive.
- Increase of stress hormones and sugar into blood stream, increase heart rate, pupils dilate, blood leaves extremities and moves to core organs.
- The brain doesn't want to waste energy on digestion or reproductive systems so it shuts them down.

The Stress Response

- The brain shifts from rational, problem solving (because you don't need to figure out complex math problems right now) to emotional and reactive (survival).
- All of this is happening to prepare you to either fight the bear or run from the bear.
- If you fight the bear or run from the bear, you are using energy, flushing out the stress hormones and brining you systems back into balance.

The Stress Response

- Or you take a second look and realize it's not a bear, it's a bunny!
- You start to calm down and you don't need to exert any energy by fighting or running.
- But you can feel that adrenaline rush in your body for quite a while until it balances itself.
- This is a great process for your survival if you rarely encounter threats to your life.

The Stress Response

- But what if you live in the forest? What if you do (or could) regularly encounter bears?
- Now you have to constantly pay attention to sounds, smells, bear tracks, dead prey, scat.
- Each sound and smell will to trigger your stress response in case it's a bear and you need to fight or flee. Now your stress response is being triggered multiple times per day for weeks and months. It's now hypersensitive and the slightest sound is perceived as a threat and the stress response goes off.

The Stress Response

- Children who experienced developmental trauma (ACEs) are regularly exposed to threats or perceived threats.
- Adults who experience complex trauma are regularly exposed to threats.
- The stress response becomes hypersensitive and is triggered regularly.
- Nadine Burke Harris refers to it as a **dysregulated stress response.**

Chronic Toxic Stress on Development

Chronic toxic stress impacts the development of the brain, the cardiovascular system, the immune system and more.

- **Endocrine-** long term changes in levels of stress hormones
- **Neurologic** – long term changes in the brain in areas that impact impulse control, reward systems
- **Immunologic** – increase in inflammation
- **Epigenetic** - changes I how DNA is read and expressed and how the brain response to stress

Toxic Stress Derails Healthy Development:

https://www.youtube.com/watch?v=rVwFkcOZHJw

(National Scientific Council on the Developing Child. n.d.)

Impacts on Pre-Frontal Cortex

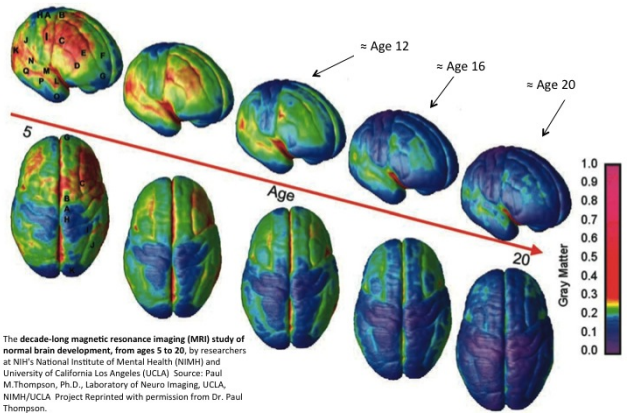
- Toxic stress impacts the pre-frontal cortex
- The Pre-Frontal Cortex is right behind the forehead – believe to be one of the last parts of the brain to evolve in humans. Has been referred to as the area where "executive functioning" takes place such as reason, judgement, planning, decision making.

- When inhibited by toxic stress it may result in:
  - Inability to concentrate and solve problem
  - Impulsive behavior
  - Aggression

Age and Brain Development

- Darker colors represent brain maturity (brain development.
- Can see how much development happens from ages 12 to 20.
- Brain keeps developing until approximately age 22 for women and 24 for males.

https://www.acesconnection.com/blog/the-developing-brain-and-adverse-childhood-experiences-aces



The **decade-long magnetic resonance imaging (MRI) study of normal brain development, from ages 5 to 20**, by researchers at NIH's National Institute of Mental Health (NIMH) and University of California Los Angeles (UCLA) Source: Paul M.Thompson, Ph.D., Laboratory of Neuro Imaging, UCLA, NIMH/UCLA Project Reprinted with permission from Dr. Paul Thompson.

The ACEs Study

ACEs study:

A research study conducted by the American health maintenance organization Kaiser Permanente and the Centers for Disease Control and Prevention. Participants were recruited to the study between 1995 and 1997 and received long-term follow up for health outcomes. The study has demonstrated an association of adverse childhood experiences (ACEs) with health and social problems as an adult.

Participants:

- 1700+
- Primarily Caucasian, college educated, upper middle class with health insurance
- Asked about early exposure to adversity and looked at health outcomes and social issues.

The ACEs Questionnaire

The ACE questionnaire:

There are 10 primary childhood (before the age of 18) traumas measured in the ACE Study.

- Five are personal, including; physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect.
- Five are related to other family members, including; a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death or abandonment.

Questionnaire: https://acestoohigh.com/got-your-ace-score/

Not a Diagnostic Tool

The ACEs Study Conclusion

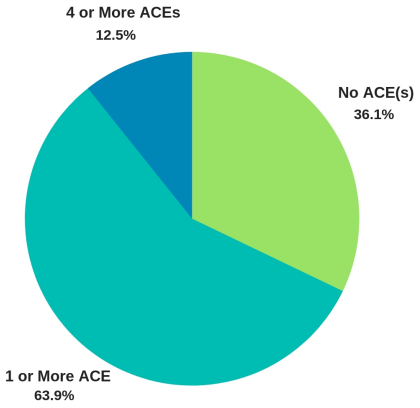
ACEs are very common:

36.1% = No ACE(s)

63.9% = 1 or more

12.5% = 4 or more

There is a strong correlation between ACEs and chronic disease, health risk behaviours and mental health problems in adulthood.



Long-Term Impact of Toxic Stress

As the number of ACEs increases, so does the risk for the following:

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease
- Depression
- Fetal death
- Educational problems
- Illicit drug use
- Ischemic heart disease
- Liver disease
- Poor work performance
- Financial stress
- Risk for intimate partner violence
- Multiple sexual partners
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity

Relative Risk

Compared to someone with no history of adverse experiences, those with four or more ACES have:

- 2.2 times as likely to have ischemic heart disease
- 2.4 times as likely to have a stroke
- 1.9 times as likely to have cancer
- 1.6 times as likely to have diabetes
- 12.2 times as likely to attempt suicide
- 10.3 times as likely to use injection drugs
- 7.4 times as likely to have an addiction to alcohol

Case Study Application

Humans don't like pain or suffering

- Most humans do not enjoy pain or suffering, whether it's physical, physiological (body's functions), mental or emotional.
- When people are suffering, what do they do in response? They try to numb the pain, avoid the pain or distract themselves.
- How do humans try to numb, avoid or distract themselves from the pain?
- Humans don't like unpleasant experiences. Without healthy coping strategies, people will use what they have to escape it.

Bad Behavior or Unhealthy Coping?

- Humans don't like unpleasant experiences and without healthy coping strategies, people will use what they have to escape it:
  - Alcohol, drugs, gambling
  - Shopping, travel, sex, exercise, food
  - Internet, tv, movies, books, video games
  - Start arguments to cause a different kind of pain
  - Self harm without intent to die
  - Harm others
  - Overbook themselves so they are constantly on the go from morning until night
  - Focus on others at the expense of their own needs

Bad Behavior or Unhealthy Coping?

- If a human was abused, violated and not respected, how might they communicate or behave in relationships (personal and professional) if they are suffering?
  - Start arguments (aggressive)
  - Avoid or stonewall people (passive)
  - Say one thing, but do another (passive aggressive)
  - Skip appointments or attend late
  - Drop out of school or quit a job
  - Lie – how might lying have kept someone safe when they were in dangerous situations?
  - "Resist" medication/treatment

CARING SAFELY CaringSafely© www.CaringSafely.org team@CaringSafely.org

Impact of Unhealthy Coping

- Impact on their physical and mental health
- Impact on their safety
- Impact on personal relationships with parents, siblings, partners, children
- Impact on the helping relationship and health care relations
- Impact on school or workplace relationships
- Impact on their ability to learn, work and earn an income to care for themselves and their family

Case Study Application

Compassionate Curiosity

- **We can't expect humans to let go of unhealthy or unhelpful behaviors and coping strategies if we don't help them develop healthy or helpful behaviors and coping strategies.**

- Important to understand or have compassionate curiosity as to why people might be engaging in behaviors that are risky or unhealthy.
- This person's current experience, situations and actions are a results of all prior experiences and actions from the time of conception until now. Next week it will be different.
- "I wonder what has happened to this person, until this moment, to create this situation." and "I wonder what we can do to help this person build resilience and learn to cope in a healthier way".

Strengths

- Most people who experience a trauma will not develop post-traumatic stress disorder **(PTSD is different from dysregulated stress response)**
- Many people who have lived through trauma or adverse experiences have developed strengths and resilience and some have even grown through post-traumatic growth.
- Having a history of trauma or adverse experiences does not mean someone will struggle forever, focusing on strengths and increasing resilience can help people overcome their impacts of past trauma.
- Trauma informed practice means knowing there is hope for everyone, focusing on strengths, connecting to resources and increasing resilience.

Strength-Based and Healthy Coping

- Instead of blaming people for their current experience, we seek to understand their history and the impact of trauma.
- Instead of asking people what is wrong with them, we ask them what has happened.
- Instead of looking at someone's experience as a disorder, we look at is as adaptation to their pain.
- Instead of labeling someone's behavior as "attention seeking" we see the individual is trying to connect in the only way they know how.
- Instead of seeing behaviors as controlling or manipulative, we see the individual trying to be assertive with their communication and power.

Resilience

- According to the American Psychological Association, "Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress — such as family and relationship problems, serious health problems or workplace and financial stressors. It means "bouncing back" from difficult experiences" (American Psychological Association, 2018)
- It is the ability to overcome and, in some cases, benefit from challenging experiences.
- Improving resilience within a trauma-informed framework is also shown to help people overcome the impacts of Adverse Childhood Experiences. (Leitch, 2017)

Building Resilience

Ways to build resilience:

- Self-trust
- Self-compassion
- Self-regulation
- Limit setting
- Communicating needs and desires
- Accurate perception of others (particularly if you have a history of ACEs/Trauma).

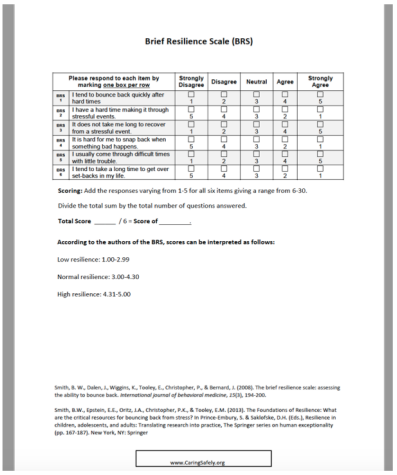
Leitch, L. (2017)

Help People Build Resilience

- Help people recognize distress (unpleasant experiences)
- Help people think of and try healthy and helpful coping strategies for distress
- Help people understand that there are reasons they are having the experiences they are having so they don't blame themselves
- Help people access resources in their community
- Help people learn how to communicate in assertive ways
- Help people increase the number of supportive people in their lives
- Help people learn how to increase their trust in themselves
- Help people learn how assess the intentions of other people
- Help people learn how to increase compassion for themselves
- Help people learn how to set and maintain boundaries

Brief Resilience Scale (BRS)

- The Brief Resilience Scale measures a person's ability to bounce back and recover from stress.



Brief Resilience Scale (BRS)

Please respond to each item by marking one box per row	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 1 I tend to bounce back quickly after hard times	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 2 I have a hard time making it through stressful events.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
BRS 3 It does not take me long to recover from a stressful event.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 4 It is hard for me to snap back when something bad happens.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
BRS 5 I usually come through difficult times with little trouble.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 6 I tend to take a long time to get over set-backs in my life.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Scoring: Add the responses varying from 1-5 for all six items giving a range from 6-30.

Divide the total sum by the total number of questions answered.

Total Score _____ / 6 = **Score of** _____

According to the authors of the BRS, scores can be interpreted as follows:

Low resilience: 1.00-2.99

Normal resilience: 3.00-4.30

High resilience: 4.31-5.00

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. *International journal of behavioral medicine*, *15*(3), 194-200.

Smith, B.W., Epstein, E.E., Ortiz, J.A., Christopher, P.K., & Tooley, E.M. (2013). The Foundations of Resilience: What are the critical resources for bouncing back from stress? In Prince-Embury, S. & Saklofske, D.H. (Eds.), Resilience in children, adolescents, and adults: Translating research into practice, The Springer series on human exceptionality (pp. 167-187). New York, NY: Springer

www.CaringSafely.org

Child/Youth

- Because children are still developing, the egocentrism of childhood often causes children who are experiencing trauma to believe they are the ones who made it happen.
- When supporting children it's important to work with parents/caregivers and the community/systems involved.
- Protective factors for ACEs include:
  - Helping children access healthy food
  - **Helping children access exercise**
  - Helping children learn how to meditate
  - Helping the family with parenting skills

Child-Parent Psychotherapy

"CPP is an intervention model for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including posttraumatic stress disorder.

The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Therapeutic sessions include the child and parent or primary caregiver.

The primary goal of CPP is to support and strengthen the relationship between a child and his or her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning. Treatment also focuses on contextual factors that may affect the caregiver-child relationship."

(The National Child Traumatic Stress Network, 2019)

Meditation

- Meditation has been shown to:
- Decreases cortisol levels,
- Balance immune system
- Improve cognitive functioning
- Decreases Inflammation
- Reverses narrowing of the arteries
- Decreases stress symptoms
- Improve quality of life
- Enhances healthy sleep

Case Study Application

Trauma-Informed Practice

Working within a trauma informed framework means the provider and/or the organization:

- Realizes the widespread impact of trauma and understands potential paths for healing;
- Recognizes the signs and symptoms of trauma in staff, clients, patients, residents and others involved in the system; and
- Responds by fully integrating knowledge about trauma into policies, procedures, practices and settings.

Trauma-Informed and Trauma-Specific

Trauma-informed services	Trauma-specific services
Work at the client, staff, agency, and system levels from the core principles of: trauma awareness; safety; trustworthiness, choice and collaboration; and building of strengths and skills.	Are offered in a trauma-informed environment and are focused on treating trauma through therapeutic interventions involving practitioners with specialist skills.
Discuss the connections between trauma, mental health, and substance use in the course of work with all clients; identify trauma symptoms or adaptations; and, offer supports and strategies that increase safety and support connection to services.	Offer services that are based on detailed assessment to clients with trauma, mental health, and substance use concerns that seek and consent to integrated treatment.

Trauma Informed Practice Guide, 2013

Question

- Does your organization discuss or implement policies inclusive of trauma-informed practice

- Yes
- No
- Unsure

Case Study Application

Principles of Trauma Informed Practice

Principles of a trauma informed approach:

- Acknowledgement – recognizing that trauma is pervasive
- Safety – create safety in the relationship and environment
- Trust – build trust in the relationship
- Choice and control – recognize the person as a expert in themselves
- Compassion – have compassionate curiosity and express compassion
- Collaboration – work together (co-create goals/plans)
- Strengths-based – review internal and external strengths, resources, past successes

(Trauma Informed Practice Guide, 2013)

Integrating Trauma Informed Practice

Integrating knowledge at all levels of contact or stage of practice:

Time of Interaction	Stage of Intervention
Connecting	Engagement
Understanding	Assessment
Desired outcome	Goals
Interactions	Intervention
Reactions/Responses	Review of intervention
Ending Contact	Termination

Connection/Engagement

Focus of stage: What is happening with a client, what could have contributed to the presenting problem and what is needed to alleviate the problem.

- Acknowledgement (trauma is pervasive, I know this person may have experienced trauma)
- Safety (how can I create safety in the relationship and environment as we meet)
- Trust (how can I build trust in the relationship in our early interactions)
- Choice and control (how can I show that I recognize the person is an expert in themselves)
- Compassion (how can I have compassionate curiosity and express compassion)
- Collaboration (how can I build rapport and be collaborative with this person)
- Strengths-based (how can I explore this person's internal and external strengths, resources, and past successes)

Understanding/Assessment

Focus of stage: What is happening with a client, what could have contributed to the presenting problem and what is needed to alleviate the problem.

- Acknowledgement (Is it part of my role to ask about past trauma?)
- Safety (as I learn about this person, I can ask what helps them feel safe and watch for behavioural cues that they are stressed)
- Trust (I can be respectful and validate this person's experience)
- Choice and control (I can respect their choices and boundaries and help them assert their needs)
- Compassion (I can have compassionate curiosity as I earn about this person)
- Collaboration (I build rapport by being collaborative with this person)
- Strengths-based (As I connect and learn about this person, I make note of their strengths and past successes)

Desired Outcome/Goals

Focus of stage: Getting clear on what outcome you both want and determining how to evaluate progression. (May want to review "Ways to Build Resilience")

- Acknowledgement (I know building resilience can help people with a history of trauma)
- Safety (I can ask them what goals they feel comfortable setting)
- Trust (I can ensure I hold up my end of the goals)
- Choice and control (I can respect their choices and help them assert their needs)
- Compassion (I can express compassion for this person as they set their goals)
- Collaboration (I can share my knowledge on what might be helpful as this person sets their goals.)
- Strengths-based (I can help this person see their strengths and build on them)

Interaction/Intervention

Focus of Stage: The interactions or interventions that will help achieve goals/outcomes.

- Acknowledgement (I know that this person's actions may be impacted by their history of trauma)
- Safety (I can help them feel comfortable connecting with me even if they haven't succeeded in a goal or in expressing any concerns)
- Trust (I can fulfill my role and be a constant person who is safe to turn to)
- Choice and control (I can respect their choices and help them assert their needs)
- Compassion (I can express compassion for this person as they set their goals)
- Collaboration (I can share my knowledge on what might be helpful as this person works towards their goals)
- Strengths-based (I can point out their strengths and normalize struggles)

Reactions and Responses/Evaluation

Focus of stage: Regularly reviewing goals and interventions. Are goals being accomplished? Did interventions help facilitate change?

- Acknowledgement (I know that this person's actions may be impacted by their history of trauma - we may have to change interventions)
- Safety (I can help them feel comfortable connecting with me even if they haven't succeeded in a goal and can explore other interventions)
- Trust (I can fulfill my role and be a constant person who is safe to turn to)
- Choice and control (I can respect their choices and help them assert their needs)
- Compassion (I can express compassion for this person as they try new ways of coping)
- Collaboration (I can share my knowledge on what might be helpful as this person tries new ways to achieve goals)
- Strengths-based (I can normalize struggles and validate ongoing effort)

Ending Connection/Termination

Focus of stage: After goals have been achieved, determine how the connection will end and what will happen next. Review resources and plans for addressing any future struggles related to the goals.

- Acknowledgement (I know past trauma can be triggered in future)
- Safety (I can help them feel comfortable trusting themselves and other resources)
- Trust (I can fulfill my role and be clear about the end of our relationship)
- Choice and control (I can respect their choices and help them set up a longer-term plan)
- Compassion (I can express compassion for this person who had gone through growth)
- Collaboration (I can help this person recognize warning signs and create a plan to respond)
- Strengths-based (I can summarize and validate their growth and potential for future)

Case Study Application

The Helping Relationship

- You are also human, with your own history, and may feel hurt, angry or defensive by various interactions with the people you help.
- As a helper, you may be on the receiving end of emotions and actions that are not about you, such as; anger, passive aggressive behavior, stonewalling, or “resistance” to treatment.
- Using compassionate curiosity to try to understand what is happening with the person you are helping can help prevent you from taking it personally.
- Know your own triggers for becoming defensive or reactive.
- It is never okay for you to be physically or verbally assaulted.

Additional Trauma Informed Solutions

- Early screening and identification
- Knowledge and awareness – preventative measures
- Access to trauma-informed programs that support healing and development
- Caregiver who validates
- Community and supports
- **Nutrition, Exercise, Meditation**

Vicarious Trauma

The transmission of traumatic stress through observation and/or hearing others' stories of traumatic events and results in a shift in your world view and sense of meaning, *"no one can be trusted"* or *"the world is completely dangerous"*.

(Saakvitne, K. and Pearlman, L., 1996)

Signs of Traumatic (Acute) Stress

Following any traumatic incident, one may begin to:

- Shield themselves from any stimuli that serve as reminders to the incident
- Avoid activities which they used to find pleasurable
- Experience cognitive deficits such as reduced concentration
- Feel emotionally detached from others.
- Feel shame, guilt, anger and/or self-doubt
- Can lead to poorer client care and increase in staff turnover

Vicarious Resilience

- "Vicarious resilience refers to unique, positive effects that transform therapists in response to witnessing trauma survivors' resilience and recovery process." (Killian et al. 2017)
- Vicarious resilience is correlated with posttraumatic growth and compassion satisfaction. Vicarious resilience is not correlated with compassion fatigue as compassion fatigue is not the opposite of compassion fatigue or burnout. (Killian et al. 2017)
- This is why it's important to focus on both the reduction of compassion fatigue, vicarious trauma and burnout as well as increasing posttraumatic growth and resilience.

Vicarious Resilience Scale (VRS)

Total score overall and total score in each sub scale

1. Changes in life goals and perspectives
2. Client-inspired hope
3. Increased self-awareness and self-care practices
4. Increased capacity for resourcefulness
5. Increased recognition of clients' spirituality as a therapeutic resource
6. Consciousness about power and privilege relative to clients' social location
7. Increased capacity for remaining present while listening to trauma narratives

- Can use for personal score now and overtime

(Killian et al. 2017)

The Professional Quality of Life Scale (PROQoL)

Assessment:

Compassion Satisfaction
Burnout
Secondary Traumatic Stress (Compassion Fatigue)

(Proqol, 2018)

Compassion Fatigue Protective Factors

Personal Compassion Fatigue Protective Factors:

- Lifestyle: relaxation, nourishment, human connection, spirituality, creativity,
- Basic Self-Care: sleep/eat/move
- Personal healing: past losses and/or traumatic experiences
- Peer support at work
- Reducing trauma-input
- Take time off from being a "social worker"

Free training at https://caringsafely.org/free-compassion-fatigue-training/

Questions and Contact Information

Any questions?

Contact Information: Charlene Richard

Team@CaringSafely.org or www.CaringSafely.org

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.)

American Psychological Association (2018). The Road to Resilience. Retrieved from https://www.apa.org/helpcenter/road-resilience

Arnold, D., Calhoun, L.G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. Journal of Humanistic Psychology, 45, 239–262.

Burke Harris, N. (2014). *How childhood trauma affects health across a lifetime.* [Video]. Retrieved from: https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime

Burke Harris, N. (2018) The Deepest Well: Healing the Long-Term Effects of Childhood Adversity

Centre for Disease Control and Prevention. (2019) About the CDC- Kaiser ACE study. Retried on January 18, 2019 from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html

Frederiksen, L. (2018) The Developing Brain &Adverse Childhood Experience (ACEs). Retrieved on January 18, 2019 from https://www.acesconnection.com/blog/the-developing-brain-and-adverse-childhood-experiences-aces

Killian, Hernandez-Wolfe, Engstrom, Gangsei, & Kendall-Tackett, Kathleen. (2017). Development of the Vicarious Resilience Scale (VRS): A Measure of Positive Effects of Working With Trauma Survivors. Psychological Trauma: Theory, Research, Practice, and Policy, 9(1), 23-31.

Kilpatrick et al. J. Trauma Stress. 2013 October ; 26(5): 537–547. doi:10.1002/jts.21848

References

Leitch, L. (2017) Action steps using ACEs and trauma-informed care: a resilience model. In *Health and justice*. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5409906/pdf/40352_2017_Article_50.pdf

National Scientific Council on the Developing Child. (n.d.). *Toxic stress derails healthy development*. [Video]. Retrieved from: https://developingchild.harvard.edu/resources/toxic-stress-derails-healthy-development/

National Child Traumatic Stress Network. Child Parent Psychotherapy. Retrieved on January 11, 2019 from https://www.nctsn.org/interventions/child-parent-psychotherapy

Proqol. (2018). *Professional Quality of Life*. Retrieved from: https://proqol.org/Home_Page.php

Richard, C. (2018), Caring Safely. Retrieved from https://caringsafely.org/

Saakvitne, K. and Pearlman, L. (1996). Transforming the Pain: A Workbook on Vicarious Traumatization

Trauma Informed Practice Guide (2013). Retrieved on March 13, 2018 from http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Van Ameringen, M., et al., Post-traumatic stress disorder in Canada. CNS Neuroscience &Therapeutics, 2008. 14(3): p. 171-181