# A PRACTICAL GUIDE **FOR CREATING TRAUMA-INFORMED** DISABILITY, DOMESTIC VIOLENCE AND SEXUAL ASSAULT ORGANIZATIONS

# Contents

# Acknowledgements

**Violence Against Women with Disabilities & Deaf Women Project of Wisconsin**

Through a federal grant funded through the Office on Violence Against Women, U.S. Department of Justice, our three statewide organizations (DRW, WCADV and WCASA) have joined together to promote our collaborative vision:

*Women with disabilities and deaf/Deaf women who experience sexual assault and/or domestic violence will be supported by people who have actively prepared for access and who think about the meaning of respect one woman at a time.*

The objectives and activities of this Project continue to be centered around:
• the distinctive dynamics of domestic violence (DV), sexual assault (SA) and stalking

against women with disabilities,
- the paramount importance of victim safety in all of its undertakings,
- the necessity for appropriate and effective services to victims with disabilities, and
- equal access through compliance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973.

Our activities and efforts have relied on two primary strategies:
1. Elevate collaboration within pilot communities among sexual assault, domestic violence and disability organizations; and
2. Enhance the community's capacity to serve women victims with disabilities and Deaf women in a manner that is accessible, supportive and culturally affirmative.

These strategies have been employed specifically with three pilot communities: the Ashland/Bayfield area; Brown County; and with a newly emerging statewide Deaf-run/Deaf victim services organization, Deaf Unity, Inc.

Within each of these communities, Disability Rights Wisconsin (DRW), Wisconsin Coalition Against Domestic Violence (WCADV) and Wisconsin Coalition Against Sexual Assault (WCASA) work to foster informal and formal relationships among organizations, Native American Tribes and groups located within these communities, while simultaneously integrating knowledge of and enhanced capacity to respond to issues of disability, trauma, violence, abuse and safety. If you have questions or would like additional information about this Project and/or issues related to the intersection of domestic and sexual violence and people with disabilities, please contact:

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# Introduction

**T**he 21st century is well underway. An exciting and transformative component of 21st century work among disability, domestic violence and sexual assault services organizations is the recognition that *togethe*r we have the capacity to positively impact the intervention with and recovery and healing of so many individuals with disabilities who have experienced or currently are experiencing violence in their lives. A key element of this collaborative transformation involves meaningful systemic change taking place throughout Wisconsin and nationally through the active integration of trauma-informed practices within and among our respective service systems.

The positive impact of a trauma-informed approach to disability-related, domestic violence and sexual assault services cannot be understated. It highlights the realities of violence experienced by so many individuals with disabilities *and* equips systems that directly serve and respond to victims/survivors with disabilities with a philosophical framework that impacts nearly everything we do.

Trauma-informed work is not just a philosophy; it's a philosophical framework that results in shifting how we think of and respond day-to-day in our interactions. Understanding *how* trauma experiences and their impact change the lens through which we see, hear and work with victims/survivors with disabilities is the journey we take throughout this guide.

# The Commonality of Trauma

**O**ne definition of trauma that will be useful when working with this guide was developed by Judith Herman in her groundbreaking book, *Trauma and Recovery*. Herman described events that are traumatic because they:

1. Render victims helpless by overwhelming force;
2. Involve threats to life or bodily integrity, or close personal encounters with violence and death;
3. Disrupt a sense of control, connection and meaning;
4. Confront human beings with the extremities of helplessness and terror; and,
5. Evoke the responses of catastrophe.[1]

The resulting trauma we talk about throughout this guide is reflected in Herman's description of possible trauma-causing events. Domestic violence, sexual assault and stalking are often experienced by the victims/survivors in terms similar to those used by Herman.

A car accident might result in trauma, but typically it involves a single event that was not caused intentionally. A car accident is an example of "acute" trauma. "Complex" trauma, also known as "psychological" trauma, involves experiences like domestic violence and sexual abuse that are intentional, interpersonal, and often repeated and prolonged. As a result, they often have lasting effects on a person's view of the world, of others, and of herself. The prevalence of psychological trauma and its pervasive impact on people's lives is significant.

## Events That May Lead to Psychological (Complex) Trauma

- The Adverse Childhood Experiences (ACE) Studies have found in a sample of over 17,000 individuals participating in a Kaiser Permanente Plan in San Diego, CA that 28.3% experienced physical abuse as children; 20.7% experienced sexual abuse; 14.8% experienced emotional neglect; 10.6% emotional abuse; 9.9% physical neglect. (CDC, 2006)

- In a large national study 52% of American women said they were physically assaulted either as a child or an adult; 18% said they experienced a completed or attempted rape at some time in their lives. Overall 55% of women had experienced either physical or sexual abuse in their lifetime. In the same study 66.4% of men reported physical assaults in their lifetime; 80% of these assaults occurred while they were children or adolescents. (Tjaden & Thoennes, 1998)

- 60% of women in military reserve units stated they experienced some sort of Military Sexual Trauma (sexual assault while serving in the military); 1.5% of these women sought care from the Veterans Administration for that trauma. (Kaiser, 2007)

## Long-Term Consequences of Psychological (Complex) Trauma

### Mental Health and Substance Abuse Problems

• A Dane County, Wisconsin study reported that among women who had used publicly funded mental health and/or substance abuse treatment services found that 83% had experienced physical abuse, 64% sexual abuse, and 89% had experienced either form of abuse. For persons with co-occurring mental illness and substance abuse problems the numbers were even higher - 92% physical abuse; 77% sexual abuse; 95% either form of abuse. (Newmann and Sallmann, 2004)

• ACE studies found that 9.5% of women with no abuse history were positive for a mental health disorder compared with 11.9% of women with histories of childhood sexual abuse, 13.7% of women who witnessed maternal battering, and 17.8% of women who experienced childhood physical abuse. 20% who had experienced all three forms of abuse had a mental health disorder and 18.9% who experienced both physical and sexual abuse had such a disorder. Emotional abuse associated with these other forms of abuse further increased the likelihood of an adult mental health disorder. (Edwards et al., 2003)

### Physical Health Problems

• The ACE studies have found increased incidence of heart disease, cancer, emphysema, fractures, and liver disease among those with higher numbers of ACEs; other studies have found a relationship between childhood abuse and irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome, and chronic pain syndromes. (Felitti et al., 1998; Springer et al., 2003)

• A study funded by the National Institute on Aging found that, "Even when adjustments were made to account for chronic diseases, social conditions and other conditions associated with increased death rates among the elderly, mistreated older persons were three times more likely to die than older persons who were not mistreated." (Lachs et al., 1998)

### People with Disabilities

• Research consistently shows that women with disabilities regardless of age, race, ethnicity, sexual orientation, or class are assaulted, raped, and abused at a rate two times greater than women without disabilities. (Sobsey, 1994; Cusitar, 1994)

• The risk of being physically assaulted for an adult with developmental disabilities is 4-10 times higher than for other adults. (Sobsey, 1994; Cusitar, 1994)

Some people with disabilities have other experiences which put them at more risk to be exploited, e.g., the culture of institutionalization. Often, the disability service system does

not offer those who need support the choice of where and with whom one lives, the freedom to come and go at will, or the opportunity to make simple decisions over one's bodily functions, such as when to eat or bathe.

Receiving services is often fraught with economic decisions that are in conflict with general principles of self-determination. Many individuals with disabilities are not earning living wages. They do not have opportunities to advance their career interests. They lack economic power. This reality for many people with disabilities can create environments where compliance to a service program or a person in authority is expected. There can be grave consequences if compliance is not given to the program or individual.

Compliance also can create opportunities for abusers to exploit a person with a disability. Compliance can be a double bind for a person with a disability. Not to comply is unsafe and compliance might also be unsafe. The long term psychological consequences due to forced compliance can profoundly affect how people with disabilities approach service or other helping relationships. Trauma-related events are too often reported by victims/survivors with disabilities in the context of these helping relationships and services, but go unrecognized as such by those in professional or support roles.

Disability, domestic violence and sexual assault services can have a positive role in the recovery and healing of individuals with disabilities who have experienced or are currently experiencing violence in their lives. A key element is a better understanding of trauma and the application of trauma-informed practices within and among our respective service organizations.

A trauma-informed approach acknowledges violence and other abuses of power and control experienced by too many individuals with disabilities. A trauma-informed approach also can help organizations to think about the point of view of each victim/survivor with or without a disability and change the way each of us interacts with and responds to those seeking services. It is not just a philosophy; trauma-informed thinking offers a practical and useful way to notice and shift our thinking so that we listen and respond in more helpful ways to each person seeking support.

*In a trauma-informed system, trauma is viewed not as a single discrete event but rather as a defining and organizing experience that forms the core of an individual's identity. The explanations about abuse, the far-reaching impact, and the attempts to cope with the aftermath come to define who the trauma survivor is.* [2]

It is our responsibility to better understand how trauma changes those who experience it. Then, we must allow that understanding to inform us in both policy and practice. A better understanding of trauma can change the lens through which we see, hear and work with victims/survivors with disabilities. A practical understanding of trauma and its impact on a person needs to be at the core of what we all do.

With a better understanding of trauma and its effects at the organizational level, we

can do better at hiring new staff, developing policies, configuring physical space, providing supervision, defining success, and so much more. It involves providing services and support "…in a manner that is welcoming and appropriate to the special needs of trauma survivors."[3]

[1] Herman, Judith. Trauma and Recovery (1992).
[2] Harris, Maxine and Fallot, Roger D. (eds.). Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift, Using Trauma Theory to Design Service Systems. New Directions for Mental Health Services, no. 89 (Spring 2001), pp.11-12.
[3] Ibid.

# Understanding the Impact of Traumatic Experiences

The indicators of trauma experienced by survivors of domestic violence and sexual assault are generally known and understood within the violence against women movements and its service organizations. Disability service organizations, through collaborative efforts to address the enormity of traumatic experiences among people with disabilities, are beginning to recognize the effects on its participants. Whether a new or well-established disability, domestic violence or sexual assault services organization or collaboration, what we think happens as a result of psychological trauma needs ongoing attention in order to support victims/survivors well.

Those of us working directly in domestic violence, sexual assault or disability-related service programs might recognize some of the effects with service recipients some of the time, but fail to recognize them at other times. Without awareness, these effects of trauma might be discussed as "challenging behavior" to be managed or modified by others. Understanding that trauma impacts "…the core of an individual's identity" means that our thinking must be trauma-informed. All of our interactions with and responses to victims/survivors should begin with the recognition that there is a strong likelihood that what we are seeing, hearing or experiencing is an aspect of or response to trauma.

## Where to begin?

When any of us is faced with real or perceived danger we often describe the experience as going on "automatic." Our thinking brain shuts off and our instincts take over. When feeling endangered our instinctual reactions are:
- Fight,
- Flight, or
- Freeze.

Think about what is involved in each of these three reactions:
- What happens to your thinking?
- What happens to your body?

When the immediate danger has passed, our thinking brain turns back on and our body returns to a more balanced state—our heart rate slows, our adrenaline subsides, our breathing normalizes, vision clears, and fear is replaced with relief. For victims/survivors of trauma, who often live in dangerous or threatening environments, the fight, flight or freeze reactions become almost continuous. As you read the following documented conditions that might be evidence of trauma, think about whether you have had contact with someone who might have been experiencing any of them.

**Hypervigilance**

Some people are always on alert; their radar is attuned to any and all potential dangers. For domestic violence and sexual assault victims/survivors, people known or unknown, regardless of intention, might be seen as dangerous. The world, this room, this building, this organization feels unsafe. Other people are unsafe. The person feels unsafe. She might take great pains to predict what might happen next. This level of fear can result in a heightened and continuous state of alert known as hypervigilance; always on guard.

In a shelter or program, a hypervigilant person might insist on knowing who is in the building. She might need to know who is currently working or who is working the next shift. She might become agitated and restless if she does not know who to expect.

*Without a trauma-informed awareness, others might characterize her as high-strung, needy, noncompliant, inappropriate, difficult or exhausting to be around rather than coping.*

**Numbing**

If a victim/survivor is not in a hypervigilant state, she might seem distant, not attentive to the environment and other people. She might seem disconnected even from herself. She might be sitting in front of you but appear unmotivated and distracted. She might or might not be listening. She might be described as looking through you and not at you.

*Without a trauma-informed awareness, she might be characterized as detached, not caring or unmotivated rather than coping.*

**Heightened Emotional States**

Some victims/survivors might express a level of emotion that seems unwarranted or extreme considering her current situation. She might cry when asked to provide an emergency contact name. She might yell at another program participant who asks about her children. She might pace the hallway outside of your office, not requesting anything in particular. Or, she might be the well-known woman who calls the crisis line at least four times each and every Tuesday evening.

*Without a trauma-informed awareness, she might be characterized as overreacting, trying to get attention or as unreliable rather than coping.*

# Shifting Our Point of View

**N**ow, consider what happens to a victim's/survivor's thinking, actions and emotions when fight, flight or freeze are continuous states. Consider the cumulative effect when being hyper vigilant, numbing or having heightened emotions are her default coping strategies. Even when the threat of danger is no longer present, it might not feel that way for a victim/survivor.

She has survived using strategies that kept her alive. These coping strategies have been her strengths when she felt endangered. They developed in the context of abusive and chaotic experiences. Being trauma-informed means recognizing and accepting these coping strategies as logical from her perspective.

While an advocate might be asking a routine question on an intake form, the survivor might be experiencing an "I'm in danger" reaction. Our challenge is to understand how trauma might be affecting one person and to learn how to be with her. How can we remain accessible to someone coping with the effects of trauma? We cannot and often do not know what constitutes a trigger for someone else. Sometimes it might be obvious, at other times it seems unrelated to the current situation or environment. That is why ongoing attention is needed so that we are considering her point of view.

## How trauma responses might explain "difficult" behavior

Consider the comparison chart below.[4] Do you see how trauma responses often look like intentional or challenging behaviors?

As you can see, what appears at first glance as a person just being difficult or challenging is reframed to reflect—from her perspective—responses she employs to keep herself safe.

| Difficult or Challenging Behavior | Trauma Responses |
| --- | --- |
| Uses substances; doesn't comply to sobriety rule | Uses substance to regulate emotions |
| Avoids meetings or groups | Avoids groups to feel safe or not feel overwhelmed |
| Paces, doesn't sleep, can't sit still | Is very alert; checking for possible dangers |
| Has "boundary" issues | Tries to get needs met; does not understand what boundaries are |
| Unmotivated, doesn't pay attention, disinterested | Shuts down emotional responses when feeling overwhelmed |

When domestic violence, sexual assault and disability organizations were asked who they find the most challenging to serve, they said people who:

- have multiple complicating factors such as inability to maintain employment, substance abuse, and homelessness;
- do not want to be helped;
- have mental health issues;
- don't take their medication;
- do not follow the "treatment plan;"
- "lie" or change their stories;
- do not follow the rules; or
- do not seem motivated to help themselves.

Our responsibility in a trauma-informed organization is to notice our judgments, impatience, disrespect, and maybe our misuse of power and control with someone who is coping with trauma in the best ways she can at this time.

## What we can do to see her point of view

With a better understanding of trauma and its impact, we can think more carefully about our individual and organizational responses to victims/survivors with and without disabilities. The next three segments of this guide highlight strategies for domestic violence, sexual assault and disability organizations to transform their current services to safe and welcoming trauma-informed services.

[4] Adapted from "Shelter from the Storm: Trauma-Informed Care in Homeless Services Settings." Hopper, et al., 2010.

# Transforming Domestic Violence, Sexual Assault and Disability Organizations into Trauma-Informed Entities

**T**o be trauma-informed, an organization and everyone involved within it must

*…understand the role that violence and victimization play … and to use that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will facilitate… their participation.*[5]

This understanding and facilitation is our task . . . so, how do we transform our organizations individually and collaboratively to rise to this challenge?

First and foremost, we have to be familiar with the dynamics of abuse so that we do not replicate these dynamics unknowingly within our respective organizations. We also recognize the principle of *first do no harm*. None of us within domestic violence, sexual assault or disability organizations work in our respective fields with intent to do harm. However, the challenge we face in transforming our organizations into trauma-informed entities is to recognize that sometimes, inadvertently and unintentionally, we retraumatize the very people seeking our services and support.

Consider the following example of how we might retraumatize the people we are intending to help:

Julie hears about a survivor's group that meets every Thursday at a service program. Julie decides to visit the program and ask about the group. She is greeted by a staff person behind a desk. Barb is courteous and welcoming. Julie is told that she must go through an intake process. During that process, Julie is read the rules for support group participation and notices that rules also are posted on a wall.

Barb later described a change in Julie. She reported that Julie became sullen, distant and distracted. Also that she seemed unmotivated and disinterested. Julie noticed a change in Barb's manner toward her. Julie excused herself and left. Barb, a bit baffled by the interaction, assumed that Julie was not yet ready to participate.

• What do you think might have happened from Julie's perspective?

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- What is Barb noticing that someone with a better understanding of trauma might have perceived differently?

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- What might someone with a better understanding of trauma consider while having this time with Julie?

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- How might a trauma-informed approach have influenced this interaction between Julie and Barb; and, how might Barb's characterizations of Julie have been different?

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## How do our organizations create a trauma-informed framework? What will that framework look like?

Trauma-informed organizations and systems proactively consider and deliberately appraise all aspects of their organizational structure, culture, operations and physical space to minimize retraumatizing service recipients. It is not enough that our intentions are to be helpful and friendly; we must question what we do and how we do it to fully gauge whether we are meeting the needs of and not retraumatizing those we serve. It is through collaboration with persons who have experienced trauma that we will learn.

Let's clarify the core values or considerations are that embody a trauma-informed organization.

[5] Harris and Fallot, (eds.). Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift,p.4.

# Conditions Embodied within a Trauma-Informed Organization

**T**his diagram represents a visual depiction of four conditions or core values that exist within organizations that embody a trauma-informed framework. The conditions overlap and build upon one another, illustrating the interconnectedness and co-existence of all four conditions within a trauma-informed organization.

Each of these conditions is described below. As you read, we ask you to reflect upon the organization where you work, volunteer or receive services. We will be asking you to draw upon your experiences to reflect upon each condition. You will be asked some deliberate and difficult questions. Linger and take your time with each condition. Note and write down your thoughts, and jot down any considerations for your organization.

**Safety and Accessibility**

**Safety and Hospitality**

**Safety and Autonomy**

**Understanding Trauma First**

## Condition 1: Understanding Trauma First

Central to a trauma-informed organization is understanding the pervasiveness and commonality of trauma experiences among organization participants, and how this shared experience can inform policies, procedures, roles, responsibilities, and the overall organizational culture. Understanding trauma and its impact becomes the lens through which all else is understood, developed, and implemented within the organization.

People with trauma histories are everywhere. A trauma-informed organization puts the victim's/survivor's perspective first. Everything that is said, practiced, and implemented is considered from her perspective and informs everything the organization does.

Understanding trauma-informed approaches also means that we have to remain self-aware as we interact each and every time with a victim/survivor. We have to be really aware of how quickly we sometimes judge someone's action (e.g., manipulative, demanding, lazy), instead of being aware that a person might just be coping.

Think about the application of this condition to your organization…

How infused is an understanding of the prevalence and impact of trauma in your written policies and procedures, and in the unwritten modes of operation, i.e. your daily practices?

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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Describe one of your organization's policies or practices that directly reflect this understanding.

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**Exercise:**
Use "guided imagery" to work through in your mind all areas of operation, and reflect upon how a trauma survivor might be impacted by these operations. For example:

- Think about what she sees, might feel and experience when calling a help line, crisis line or warm line?

- How is she greeted?

- What information is she asked to provide and why? Is the information requested essential to have at this time or just a matter of convenience for staff?

- *Imagine you are this survivor; this woman.*

- What rules is she expected to follow?

- How do you share information about her?

- What does she get to decide?

- Walk through every possible operation of your organization including things you think she might not see or be aware of (e.g., a staff meeting).

- Make sure to note how she might experience something as helpful, confusing or even harmful.

Your notes here of your initial thoughts:

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What did you notice from this exercise? What did you notice as something that might need adjustment to be more respectful of someone coping with the effects of trauma; i.e., to be more trauma-informed? Look through your notes and what you jotted down. Identify some priorities for implementing a trauma-informed perspective into your daily organizational practices. Note what could be addressed right away, and what might require more planning and effort to implement.

List three changes you could implement immediately to be more trauma-informed:

**Change 1** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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Anticipated outcome from instituting this change:

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How will you know if it's working?

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**Change 2:** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Anticipated outcome from instituting this change:

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How will you know if it's working?

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**Change 3**: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Anticipated outcome from instituting this change:

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

How will you know if it's working?

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Now, list three actions that are needed to be more trauma-informed, but will require some planning and time:

**Action 1:** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Target date to begin planning for action:. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Stakeholders needed for planning: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Define objectives of planning group: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Define action steps for planning group:

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Set target date to commence trauma-informed action:. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Implementation steps for incorporating the change (e.g., notice, training):

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Action 2 : . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Target date to begin planning for action: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Stakeholders needed for planning: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Define objectives of planning group: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Define action steps for planning group:

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Set target date to commence trauma-informed action: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Implementation steps for incorporating the change (e.g., notice, training):

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Action 3:** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Target date to begin planning for action: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Stakeholders needed for planning: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Define objectives of planning group:. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Define action steps for planning group:

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Set target date to commence trauma-informed action: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Implementation steps for incorporating the change (e.g., notice, training):

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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**A note about safety**

Generally, we think of safety as the condition of being or feeling safe, taking measures to prevent harm, and the freedom from danger. Of course, what it means in practice varies and depends on context and perspective. **For our purposes throughout this guide, it's imperative that we think of safety and what it means from a victim's/survivor's perspective.** How we think about safety will change with every person, every interaction and in every situation we encounter. A sense of safety might also change over time and to some degree be in relation to how a person feels treated.

## Condition 2: Safety and Autonomy

For trauma-informed organizations, safety is defined from the trauma survivor's point of view. One aspect of safety comes into play when our words and actions demonstrate that we value victim/survivor autonomy. Self-determination is based on the philosophy of autonomy. Self-determination describes the capacity to choose what action to take rather than that action being chosen for us by someone else. To exercise personal autonomy, a victim/survivor must have the information that is vital to make informed choices. It's about making decisions on her own behalf without being compelled by others. Autonomy, then, also implies safety—for her.

While it might seem obvious what autonomy means, in actual practice it becomes more complicated. When people seeking support are from different generations, ethnicities, and cultures and have different abilities, it is not always clear what will be experienced as promoting autonomy. Choice, in the context of a trauma-informed organization, is not just about what is offered. Choice exists on a spectrum that is intentionally linked to creativity, new opportunities and honoring the diversity of interests and perspectives of participants. Some of these interests and perspectives might be personal and some cultural.

Autonomy and safety are linked in the context of a person's privileges and rights. When we recognize someone's right to informed consent for release of information, for example, it allows her to know that she will be consulted before something is done on her behalf.

What is reported as unsafe in many service organizations is frequent gossiping and the lack of confidentiality. When information and characterizations are carried "outside the door" of the room or organization, the safe environment inside is lost. This dynamic results in a loss of safety for all participants. Respectful boundaries are expected within and outside the literal and figurative walls of the building.

Autonomy and safety within a trauma-informed organization also means that we follow the lead of and collaborate with a victim/survivor with disabilities. She sets the agenda for what she wants to accomplish and how; she sets the pace—literally; she makes the decisions that work for her. While you might have suggestions, wish she would make different choices, or feel she is being uncooperative, with trauma-informed awareness we see her as autonomous and making decisions that help her to feel in control. Personal control is another aspect of safety.

Another context for understanding safety and autonomy from a victim's/survivor's perspective is your organization's environment. An emotionally safe environment is one that gives each woman a sense that she is free to express herself. This expression can include feeling low, frustrated, happy – whatever she feels emotionally will not automatically be received with a traditional response: e.g., did you take your meds today?

Think about the application of this condition to your organization…

Your notes here about adjustments that might be helpful:
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Now, consider the following situations and reflect on how safety and autonomy come into play:

• Jodi overhears two staff members talking about her recent crisis while they are getting coffee, as Jodi happens to be going to the office of another staff member.

• Maya is upset, crying, and wanting the attention of staff. She is told that she will need to see a psychologist or counselor for the kind of attention she needs; and, she will need to be quiet while in the shelter because she is upsetting others.

Your notes here about how safety and autonomy interplay in these examples:

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

## Condition 3: Safety and Hospitality

Being hospitable and inclusive is the foundation to meaningful participation. A central condition highlighting the unique and empowering character of trauma-informed service organizations is hospitality and inclusiveness. What differentiates a trauma-informed organization is the richness of what "hospitable and inclusive" really mean.

Hospitality literally means to equalize power between people, especially in the context of someone who is not known to the one inviting, or hosting. Inclusive also carries this idea; as in welcoming and being thoughtful toward those who are usually not served. Inviting someone who has previously been excluded or screened out carries with it the responsibility to check the balance of power between the one served and the one serving; or, between the one hosting and the one hosted. The goal is that the person invited in feels welcome and at home, i.e., safe.

Creating hospitality and inclusiveness, then, involves fostering choice and opportunity, and embracing the diversity of ways that people find meaningful to participate. It relies directly on interactions that are respectful and welcoming. It requires that organizations continuously evaluate and take action to ensure that enthusiasm among participants and within the organizational structure and operations is maintained. It calls for openness and transparency in communication, interactions and access. Think about how these modes of operation would feel to a victim/survivor. Notice how openness and transparency, for example, relate to a feeling of safety for each participant within your organization.
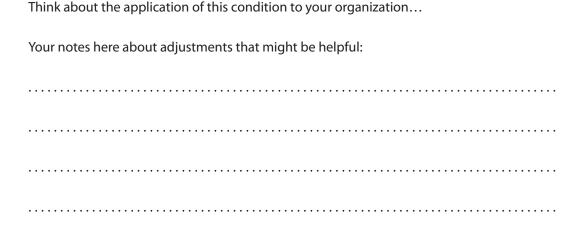
Think about the application of this condition to your organization…

Your notes here about adjustments that might be helpful:

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Now, consider the following situations and reflect on how hospitality and safety come into play:

- Dawn has been asked to leave the program because a staff member learns that Dawn has been violating the sobriety rule.
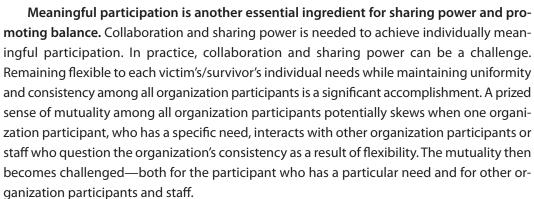- Mathara cannot be included because she is perceived as too symptomatic to participate at this time.
- Shelly has issues the provider does not address. She would be better served by another agency that addresses the violence and trauma.

Describe how you think hospitality and safety are experienced by Dawn, Mathara and Shelly:

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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How is meaningful participation and choice challenged in the above situations?

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

For example, consider Mathara to be an individual who participates in a disability organiza-tion and who appears to be more "ill" than another individual:

How is Mathara, as a person too ill to contribute to the organization, limited in access to serv-ices or support?

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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How does this affect Mathara's ability to contribute to the organization?

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

How might this characterization retraumatize Mathara?

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

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Hospitality and safety also address power dynamics within an organization. Trauma-informed support relationships tend to be more mutual than those relationships that do not balance the power between "helper" and "helpee." Abuses of power and control have been at the center of what victims/survivors have experienced. Being mindful of the inherent power imbalance between service provider and service recipient is a key element of collaboration and sharing power. The intent is to recognize the imbalance and minimize its potential to trigger and retraumatize a victim/survivor.

**Meaningful participation is another essential ingredient for sharing power and promoting balance.** Collaboration and sharing power is needed to achieve individually meaningful participation. In practice, collaboration and sharing power can be a challenge. Remaining flexible to each victim's/survivor's individual needs while maintaining uniformity and consistency among all organization participants is a significant accomplishment. A prized sense of mutuality among all organization participants potentially skews when one organization participant, who has a specific need, interacts with other organization participants or staff who question the organization's consistency as a result of flexibility. The mutuality then becomes challenged—both for the participant who has a particular need and for other organization participants and staff.

Understanding the impact of these challenges can affect the day-to-day operations of the organization, its overall environment, and how each organization participant experiences her/his place within it. It can affect a person's feeling of safety and hospitality. Acknowledging and managing these effects from each victim's/survivor's perspective represents a core value practiced within trauma-informed organizations.

## Condition 4: Safety and Accessibillity

By accessibility, we mean access in its broadest sense. It includes standards in accordance with the Americans with Disabilities Act and Amendments, Section 504 of the Rehabilitation Act of 1973, and state-level access requirements. Access also encompasses the development and use of policies and procedures that are trauma-informed. It is not just buildings and meeting spaces that need to be accessible. People have to remain accessible, too.

A key aspect of access that will arise daily is the challenge as a provider of services to remain accessible—open and trauma-aware—during all interactions, especially ongoing relationships with organization participants.

- With her physical abilities, Melinda can't get into a service program's building. If she wants services she will have to meet a staff member of the program at a motel.

- TJ walked into a meeting room and saw cramped and crowded chairs and felt the need to leave immediately.

- Rosa heard the person she thought was going to help her say; *we've already talked about that. We're done.*

- Lydia noticed that staff and volunteers were talking with each other. She has trouble putting words together. They seemed busy. She stopped trying.

- Randy started shaking her head and saying *no, we don't do that, you can't do that, you need to…* At that point, Lisa called Randy every foul name she could think of.

It might be your intention to be open, but staying open and accessible is not always easy. We do things and say things without too much thought.

> *Part of being trauma-informed is remembering that what we do and say always matters when it connects so directly with another person's sense of safety.*

On any given day something will happen that might cause us to tighten, to judge, to become angry, to worry or feel disappointed. How will that show up in you? A look, a change in your tone of voice, a turn of the head, a roll of the eyes and someone's sense of safety is threatened.

Learning to take care of ourselves and each other while supporting victims/survivors with disabilities is an enormous part of the work. It does not matter how long you have been doing the work; learning to stay accessible so that others can feel safe is a lifetime practice.

Think about the application of this condition to your organization…

Your notes here about adjustments that might be helpful:

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How accessible is your organization—physically, emotionally, attitudinally and in its policies and procedures?

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What concrete steps could you employ to enhance overall access?

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How are ideas, suggestions for changes or improvement in operations welcomed and dis-cussed among staff and organization participants?

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Would you characterize the culture of your organization as trauma-informed? How? Why?
Why not?

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What might you need to change to nurture a more meaningful, trauma-informed culture
within your organization? How would you change it?

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**Summary of Trauma-Informed Conditions for Organizations: A Story**

To summarize what an organization that embodies these four conditions would be like, consider what a person might say about an organization that was experienced as trauma-informed:

When I was seeking services [disability-related support, crisis intervention, shelter, etc.], I found understandable information about the service [organization, program, support group] easily. The directions to the facility were made available and easy to follow.

When I arrived, I was greeted in a friendly and welcoming way. The facility was lit well, clean, and had comfortable furniture and decorations that helped put me at ease. The staff/volunteer provided me with concise information on what I could expect from the people and services they offered. When they said they would do something for me, they did it. I felt respected by all those who worked with me. They also explained what they expected from me and asked whether I would need any assistance or accommodations.

The staff/volunteers didn't assume they had to do everything for me. I felt empowered to make meaningful choices along the way. They worked with me and I made the decisions about things that impacted me. I felt supported to make the decisions that affected me. I had a great amount of choice about when, where, how, and by whom services/support were provided.

I was able to exercise my creativity and my skills and strengths in making decisions and solving problems. My cultural choices were respected. My experience with trauma was validated, believed, and when I was afraid, staff/volunteers asked me what might be helpful and understood that I sometimes did things that didn't make sense or feel comfortable to them. They tried to understand why I approached a situation that felt unsafe to me in the way that I approached it.

When I seemed stuck, they offered choices that might help get me unstuck. I felt safe because I had the choice to do something different or to do something that was familiar to me. When I told secrets or painful things about my history, they didn't share it with others. If they felt like they might need to share information about me with others, they talked with me first. I was able to control what information was shared.

They also asked me frequently about how things were going and how they might improve supporting me. About a year later, they were making some changes to their services and they contacted me for feedback and input into what I thought might be helpful. I thought that was great. No one had asked me before to be part of that kind of planning. Since using the services, I have had the opportunity to let other people know how safe I felt and that the services this organization had to offer might be helpful to someone else who faced a similar situation as I did.

# Practices that Infuse Trauma-Informed Organizational Change

**A**ccording to Harris and Fallot:

> *An administrative commitment to becoming trauma informed begins when the people who allocate resources, set priorities, and sponsor or design programs assert trauma and its aftermath are an important part of what ails people. This statement resonates much more loudly when it is backed up by training, changed policies, new hiring, and enhanced services.*[6]

Our awareness about trauma and its impact for organizations means that the considerations and core values (understanding trauma first, safety, autonomy, hospitality and accessibility) are infused throughout. Through deliberate action, trauma-informed organizations expect that trauma-informed approaches will impact every level of organizational operation, organizational culture, services and delivery.

Infusion of trauma-informed practices will change the training needs of staff and volunteers so that they feel equipped to serve in their roles competently and confidently. It will change the criteria we use to evaluate prospective candidates and hire new employees. It will change what our written policies and procedures say so that they now reflect her perspective—the trauma survivor's perspective. Our forms, which often drive our procedures and processes, will reflect a new awareness and understanding about how each question, each bit of information might impact a woman seeking our support.

How could an organization committed to these changes ensure that trauma-informed goals and practices are maintained? This question is an important one because we are genuinely committed to supporting victims, survivors and people with disabilities. An often overlooked avenue for effectively infusing a trauma-informed framework into day-to-day operations is through supervision practices.

## The Pivotal Role of Supervision in Organizational Change

In almost every human service organization, one of the most underused methods of creating organizational change is supervision. A training session is the norm. We send people out for training and bring people in to provide it. Training can offer new information and ideas; it can result in some excitement and maybe a renewed enthusiasm for the work. In practice, most people return to the rhythms and patterns of how they approached their work before training. For people in paid and volunteer positions (in disability, domestic violence and sexual assault organizations) to actually apply and refine what they learn in training,

something has to invite continued thinking about, and application of, that training content. Supervision is a perfect vehicle for that.

When asked about supervision, too many direct support people say that supervision consists of being asked about their paperwork—the business of their jobs rather than their experiences and relationships on the job. In a field that we call 'human services' it seems negligent to not talk about human interactions. This is especially true when the reason for contact is that someone is living with anything from confusion to chaos to violence. As extreme as this is for the person living with it, the effects on service and support providers can be significant as well. A time, place and person with whom to review what happened and consider how else a similar situation could be approached in the future seems the least that could be offered.

In the context of trying to achieve organizational growth so that people both understand what creates trauma and then how a victim/survivor's whole life and daily interactions are shaped by that trauma, some attention is warranted. People have spoken about how they experience misuses of power and control in the places established to help them.

- Too many have been called names they found offensive *(manipulative or lazy)*.

- Too many have felt overwhelmed with forms that they were told had to be completed before anything else could happen.

- Too many have been told what they had to do *(return to work, see a psychiatrist)* on someone else's schedule and for someone else's reasons.

- Too many have been lectured about safety, risk, and told what not to do, when they did not ask anyone for advice.

- Too many have been told that their ways of taking care of themselves were not allowed, when they were generations old cultural or family practices.

- Too many have felt restricted or punished for having revealed anything at all. Too many others have felt dismissed or ignored when looking for help.

- Too many have left before receiving any meaningful support because they found someone's attitude, manner, language, speed, intensity, etc. condescending, intrusive or aggressive.

- Too many left with nothing but more fear and confusion about who is trustworthy and safe.

On the other side of these many people who did not find what might have helped them out of a difficult or dangerous situation was one person who believed that she or he was

doing a good job. This staff person, volunteer or family member might continue to believe that she or he did a good job because there was no opportunity to reflect on the contact.

That person, who believes that she is doing what she does well, might have that positive view of herself strengthened when others where she works characterize people as *difficult, challenging, or uncooperative.* She might hear that some adults are like children and need to be treated as such. He might hear some described as *low functioning or just wanting the attention.* They might justify their actions and feel OK about their roles, thinking *I did everything I could do; she just didn't want to be helped.*

Good supervision should catch this faulty thinking and create opportunities for change. In order for a supervisor to make use of that opportunity, she or he has to understand well the meaning and implications of trauma. She has to understand the difference between characterizing a person and reporting a person's actions. It is the difference between characterizing her as *lovely* and reporting that *she patted my hand when she spoke to me.* It is the difference between characterizing her as *an angry and aggressive woman* and reporting that *she stood while talking loud enough that people in the waiting area could hear her and waved her fist at me.*

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*Good supervision invites reporting, reflection, consideration of multiple perspectives, and imagined do-overs in preparation for future encounters—all with a goal of being accessible to each and every person who might want assistance.*

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With that in mind, regularly scheduled consultation conversations might include questions like the following:

- To start, describe what happened. Is that a characterization or a report? For now, try to keep judgment and analysis out of it and just report what happened.

- What do you imagine it was like for her—from her perspective? Describe what she might have been seeing, feeling, thinking or remembering.

- What parts of this encounter were difficult for you? What did you notice happening to you— your thoughts, feelings and energy?

- Do you think your goals during this encounter were in agreement with her goals? How were they different?

- When you think about who was in charge during this encounter, setting the agenda and the direction, where was the power mostly, with you or her? How do you think that worked out from her perspective? What makes you think that?

- What do you think she noticed most about you and your style of interaction? Assume she is talking about you right now; what do you think she is saying? What do you think she might be saying about our organization and what we do?

- Given what we've talked about, think about anything you might do differently if you were starting again. In particular, think about adjustments that might result in this particular person feeling respected and safe. What would you do differently?

So far, we have focused on a traditional model of a supervisee and supervisor. There is nothing that says the kind of conversation described above could not take place between peers. The point is we all need to have these kinds of conversations in order to stay mindful about what we are doing and why. When someone reaches out for assistance, someone needs to be there ready and able to meet her in ways that she experiences as helpful and safe.

Imagine what might happen if all of the individuals representing all of the organizations that try to support women with disabilities who have experienced domestic violence, sexual assault or stalking engaged in this kind of conversation regularly. What if we had these conversations not just when something went terribly wrong, but as a routine part of our work? It seems highly likely that a much better understanding of what is meant by trauma-informed would emerge.

## Practical Tips to Consider

- Train all staff and volunteers in trauma and what it means to be trauma informed.

- Continually refine practice through supervision.

- Encourage mentoring and working together to reinforce learning.

- Invite and value honest feedback from staff, volunteers, and program participants. Create a safe environment that encourages sharing regarding program, policies, procedures, and practices.

- View complaints and grievances as a valuable aspect of the feedback loop.

- Hire/recruit volunteers who have been program participants. They offer valuable insight "having been there."

- Understand that staff and volunteers can be reminded of past or current trauma while going about doing their daily work. Offer supports, sufficient time off, and periods of rest. Being reminded of trauma [triggered] is not a weakness. It is a response that needs administrative support and compassion in order to accomplish the work of providing services. Have a "how may I assist you in your work" approach to workers who are retraumatized.

- Have resource material on trauma and trauma-first approaches readily available to staff and volunteers and program participants that encourages ongoing learning and mutual support.

- Utilize "person-first" language in speaking of people whether they are in your presence or not.

- View failures and successes as learning opportunities. Document what has worked best and pass it on to others. What works best can be discovered by anyone in the organization. All have expertise that can be built upon and shared.

## Practice trauma-informed universal safeguards

Doctors wash their hands because they assume they are carrying agents that could do harm to their patients. The exam room also is carefully disinfected. Supplies are kept sterile. They wear gloves not only to protect themselves, but to protect the patient from any further harm by what they may have brought into the room with them. This practice is meant to limit the harm that can come to a patient by visiting a medical environment. In medicine, this is known as "universal precautions." *Universal* means that all spaces and all personnel are trained in these precautions—from housekeeping to the surgeon.

We can learn from this model of *universal precautions* to create *universal safeguards* to prevent retraumatizing those who seek services. Listed below are some safeguards to help prevent retraumatization of victims/survivors. First, let's consider everyday safeguards in our interactions among staff, volunteers, advocates and program participants. It might be helpful to:

- …avoid forcing a lot of eye contact when speaking with her. It doesn't mean she isn't listening, but she might feel safer if she doesn't have to have a lot of eye contact.

- …be aware of your proximity to her. It might be helpful to stand or sit off to one side, but not right in front of or right next to her. Watch for what she is saying feels safe by her body language. Respect the distance she might be putting between you and her.

- …be engaging but not overly "gabby." Pause long enough to allow her to form a response. This pause may take longer than you are normally comfortable with. If she seems stuck, it is ok to ask "Do you need some more time to reflect about _____?"

- …avoid asking too many questions in a row. Ask yourself, is this information I am asking for right now necessary to gather right now? If it can wait, let it wait until she is more comfortable and in a place to be responsive.

- …offer frequent breaks or break up the "hard stuff" into smaller sessions with non-threatening activities such as offering time for something creative to happen, a coffee break, or a snack break.

- …allow emotions to rise. Remember, this might be her safe place where she can express her emotions.

- …avoid platitudes. Some things really do suck the words right out of you. Be willing to sit in supportive silence with her.

- …to ask at these emotional times, "How may I assist/support you right now?"

- …to say "I don't know" or "I am at a loss" rather than to offer supports or services you cannot fully deliver.

- …draw upon her resiliency. Ask what has helped her in the past. Operate from a place of source, abundance, and strength. She has survived and has a host of resources to draw from. You might be the one who remembers that for her at this time.

- …ask first if it is okay to touch before touching, hugging, or offering any supportive ges-tures in this manner.

- …reflect and clarify what she has communicated. "Did I understand this correctly when you said _____?" If you need clarification, it sometimes is helpful to ask, "Can you tell me more about that?"

**Everyday universal safeguards** employed to uphold programmatic goals that you might try when offering your services/support:

- Provide as much choice as possible. Work to create choices based on what she states is helpful.

- Provide clear information about when, where, and by whom services and supports will be provided.

- Ensure choices are voluntary. Avoid the temptation to coerce or talk her into choices you think are the best for her.

- Do ask what are her goals and priorities.

- You may have to repeat the rules and other information many, many times. Accept this repetition as a practice to ensure a trauma-informed environment rather than under-standing her as non-compliant or resistant. Also avoid posting rules all over the place. This can create an environment that focuses on compliance rather than creating safety, feels unsafe and controlling, which is usually opposite of the intended effect of rules. It may be helpful to provide this information in a packet that she can refer back to if needed.

- Be attuned to cultural differences that might look like "bad" choices or practices to you. It is always a best practice to be open to differences and try to understand cultural reasons for what she does. Foster curiosity about differences.

- Ask often what is helpful for her, and what works for her. Build upon her strengths and life experience.

- Help her to mentor you as you grow in your knowledge and skills in working with her. Allow the learning process to be reciprocal and authentic and dynamic.

Any helpful safeguards you might add?

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[6] Harris and Fallot, (eds.). Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift, p. 6.

# Exercise: Revisiting Julie and Barb's Interaction

**E**arlier in this guide on pages 19-20, we asked you to consider a short scenario involving Julie and Barb. We then asked you to take a few minutes and respond to several questions that followed that scenario. ***Please, don't look back at your responses on pages 19-20 … yet.***

Now, reread this same scenario (**below**). Jot down your answers to the same four questions.

Julie hears about a survivor's group that meets every Thursday at a service program. Julie decides to visit the program and ask about the group. She is greeted by a staff person behind a desk. Barb is courteous and welcoming. Julie is told that she must go through an intake process. During that process, Julie is read the rules for support group participation and notices that rules also are posted on a wall.

Barb later described a change in Julie. She reported that Julie became sullen, distant and distracted. Also that she seemed unmotivated and disinterested. Julie noticed a change in Barb's manner toward her. Julie excused herself and left. Barb, a bit baffled by the interaction, assumed that Julie was not yet ready to participate.

What do you think might have happened from Julie's perspective?

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What is Barb noticing that someone with a better understanding of trauma might have perceived differently?

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What might someone with a better understanding of trauma consider while having this time with Julie?

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How might a trauma-informed approach have influenced this interaction between Julie and Barb; and, how might Barb's characterizations of Julie have been different?

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Now, take a look back at the answers that you noted for these questions earlier in this guide— located on page 17. Compare your two sets of responses. Notice the similarities and differences between what you jotted down in your answers on page 17 and your answers noted above:

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Were any of your responses to the questions different from what you noted in the earlier segment on page 17?

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Describe what changes, if any, you identified between your initial answers and the ones above in your descriptions about Julie's perspective…

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Describe what changes, if any, you identified between your initial answers and the ones above in your descriptions about Barb's perspective and responses…

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What specific ideas or strategies emerged in your answers described above that was not present in your earlier responses on page 17?

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If your responses did not change, were the words you used different? How were they different? What led to these differences in terminology?

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When you compare the similarities and differences that you identified in this exercise, describe the characteristics of what a trauma-informed interaction would involve for you.

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# Closing Reflections

**T**rauma-informed considerations and core values are about stripping away the differences and recognizing the humanness of connection. Regardless of the path that leads someone to a helping organization (domestic violence, sexual assault or disability), a trauma-informed approach should await them—an authentic place of safety, recovery and hope.

An important part of becoming trauma-informed is noticing how "the problem" that has been viewed as a person's resistance, might really be a reaction to the dehumanizing effects of violence and trauma in people's lives. This understanding is critical because it highlights what is so transformative about a trauma-informed approach.

Embracing a trauma-informed approach as individuals, as organizations and as collaborations among organizations highlights the considerable power to promote meaningful hope and healing for each person. The healing power of trauma-informed practices are that they eliminate what people have experienced as dehumanization, and return helping organizations to humanness—to places of autonomy, hospitality and safety.

# Resources and Technical Assistance

**Wisconsin Project Contact Information:**
Wisconsin's Violence Against Women with Disabilities and Deaf Women Project
Amy Judy, Project Coordinator, Disability Rights Wisconsin
800-928-8778 (toll free for consumers and family members only)
608- 267-0214  (Voice)
888- 758-6049  (TTY)
amyj@drwi.org  (Email)
www.disabilityrightswi.org (Web site)

**Wisconsin's Trauma-Informed Care Initiative:**
http://www.dhs.wisconsin.gov/mh_bcmh/tic/index.htm  Wisconsin State Trauma-Informed Care (TIC) Educational and Media Campaign. Psychological trauma is a pivotal force that shapes people's mental, emotional, spiritual and physical well-being. Because trauma stems from many events (e.g., violence, abuse, neglect, disaster, war, etc.) nearly every family is impacted in some way. Trauma-informed care provides a new perspective; one in which those providing support and services shift from asking *"what is wrong with you?"* to *"what has happened to you?"*  This change reduces the blame and shame that some people experience when being labeled with symptoms and diagnoses. It also builds an understanding of how the past impacts the present, which effectively makes the connections that progress toward healing and recovery. For more information about the 'Shift Your Perspective' campaign, contact: Elizabeth Hudson at Telephone: (608) 266-2771 or by Email: Elizabeth.Hudson@ wisconsin.gov.

Listed below are a variety of trauma-informed resources.  This list is based on a compilation provided by Ann Jennings, Ph.D.

**ACE Study**
**www.cdc.gov/nccdphp/ace**
The Centers for Disease Control and Prevention reports on the Adverse Childhood Experiences (ACE) Study—one of the largest investigations ever conducted on the links between childhood maltreatment and later-life health and well-being. As a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego, Health Maintenance Organization (HMO) members undergoing a comprehensive physical examination provided detailed information about their childhood experience of abuse, neglect, and family dysfunction. Over 17,000 members chose to participate. To date, over 30 scientific articles have been published and over 100 conference and workshop presentations have been made.

**The Adverse Childhood Experiences Study**
**www.acestudy.org**
Primary focus is to share the findings of the Adverse Childhood Experiences Study, in a format readily accessible to both professionals, and the lay community. A free, electronic, quarterly publication, ACE Reporter, about the findings of the Study is available on line.

**The Anna Institute**
**www.theannainstitute.org**
The Anna Institute celebrates and honors the life of Anna Caroline Jennings, by using her artwork and life experience to educate others on the hidden epidemic of childhood sexual abuse, its horrific impacts on individuals and society, and paths to prevention or healing. Download articles and PowerPoint presentations of Anna's life as a child and as a mental health patient. Visitors can view an on-line gallery of Anna Caroline Jennings' powerful artwork, most of which was created within the walls of state mental institutions.

**National Center on Domestic Violence, Trauma & Mental Health**
**www.nationalcenterdvtraumamh.org**
The National Center on Domestic Violence, Trauma & Mental Health provides training, support, and consultation to advocates, service providers, legal professionals, and policymakers as they work to improve agency and systems-level responses to survivors and their children. The work of the Center is survivor defined and rooted in principles of social justice.

**The Child Trauma Institute**
**www.childtrauma.com**
The Child Trauma Institute site includes parent information, trauma measures, publications, training programs & links. The Institute provides training, consultation, information, and resources for those who work with trauma-exposed children, adolescents, and adults.

**Darkness to Light**
**www.darkness2light.org**
Darkness to Light raises awareness of the prevalence and consequences of child sexual abuse by educating adults about the steps they can take to prevent, recognize and react responsibly to the reality of child sexual abuse.

**The Domestic Violence and Mental Health Policy Initiative (DVMHPI)**
**www.dvmhpi.org/**
DVMHPI is an innovative Chicago-based project designed to address the unmet mental health needs of domestic violence survivors and their children.

**Gift From Within**
**www.giftfromwithin.org**
A site for survivors of trauma and victimization, Gift From Within gives trauma survivors,

their loved ones and supporters a credible online website that is friendly and supportive. Explains the condition of PTSD without being too technical or too superficial. Gift From Within believes that persons with PTSD and related traumatic stress syndromes deserve the same respect and support that individuals and families suffering the impact of cancer, heart disease and stroke receive.

**Healing Self Injury**
**www.healingselfinjury.org**
Healing Self Injury provides information about self-inflicted violence and a newsletter for people living with SIV– The Cutting Edge. Published by Ruth Mazelis and now in collaboration with the Sidran Institute, The Cutting Edge is in its 15th year of publication. It serves as a resource for those seeking information on this often-misunderstood issue and includes editorial commentaries, written and artistic contributions from the readership, and reviews of various resources for those who live with SIV.

**National Center for Posttraumatic Stress Disorder**
**www.ncptsd.va.gov**
Research and education on PTSD; includes the PILOTS Database, an electronic index to PTSD literature.

**The CMHS National Center for Trauma Informed Care**
**http://mentalhealth.samhsa.gov/nctic/**
The CMHS National Center for Trauma Informed Care provides trauma training and technical assistance to assist in the transformation of publicly-funded agencies, programs, and services to an environment that is more supportive, comprehensively integrated, and empowering for trauma survivors. Site provides information and available trainings. CMHS's National Center for Trauma-Informed Care links to publications and studies on trauma.

**National Child Traumatic Stress Network**
**www.nctsnet.org**
To raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States.

**National Sexual Violence Resource Center**
**www.nsvrc.org**
Serves as the nation's principle information and resource center regarding all aspects of sexual violence. It provides national leadership, consultation and technical assistance by generating and facilitating the development and flow of information on sexual violence intervention and prevention strategies. The NSVRC works to address the causes and impact of sexual violence through collaboration, prevention efforts and the distribution of resources.

**Sidran Institute**

**www.sidran.org**

Sidran Institute helps people understand, recover from and treat traumatic stress (including PTSD), dissociative disorders, and co-occurring issues, such as addictions, self injury, and suicidality. Sidran develops and delivers educational programming, resources for treatment, support, and self help, trauma-informed community and professional collaboration projects, and publications about trauma and recovery.

**The Trauma Center at Justice Resource Institute**

**www.traumacenter.org**

Helps individuals, families and communities that have been impacted by trauma and adversity to re-establish a sense of safety and predictability in the world, and to provide them with state-of-the-art therapeutic care as they reclaim, rebuild and renew their lives. Articles by Bessel van der Kolk, MD, Medical Director and Founder of the Trauma Center and internationally recognized leader in the field of psychological trauma, are available on this site.

**Witness Justice**

**www.witnessjustice.org**

Witness Justice addresses gaps in victim services by offering direct services for survivors of violence and their allies who are experiencing difficulties. Witness Justice offers assistance and support to get answers, explanations, information, and resources for the many survivors who feel "stuck" or "lost" following violence and trauma.