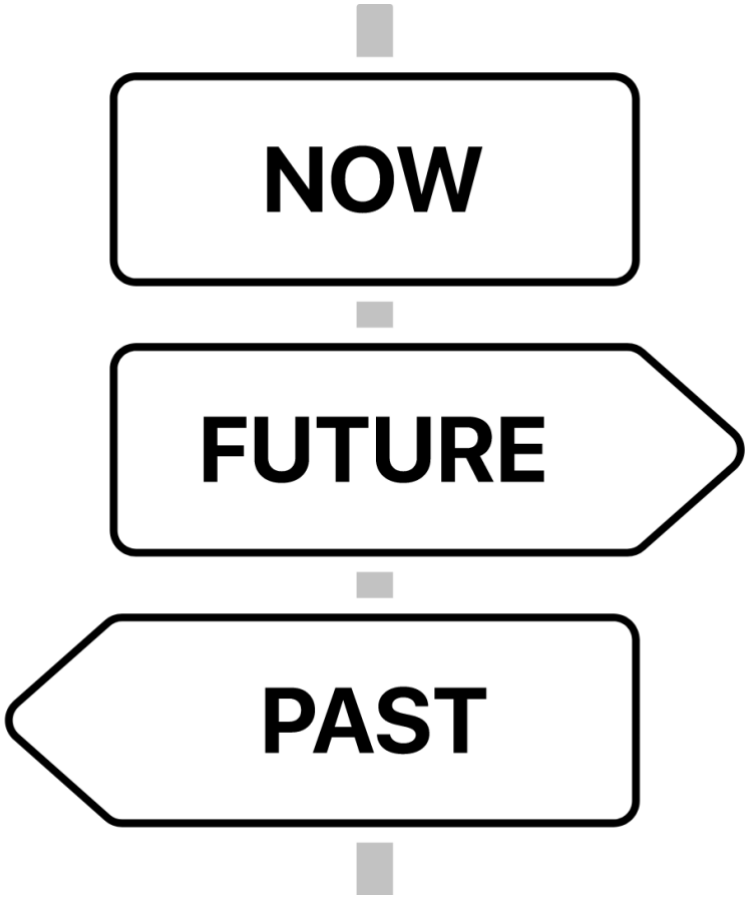
The Mental Health Field and Insidious Trauma



Gwendolyn "Gwen" Downing (she/her), LPC
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Opening

Acknowledging lived experience of the group, with all the differing degrees, as we proceed, we keep that in mind.

Training description:

Insidious trauma is the daily incidents of marginalization, objectification, dehumanization, intimidation, et cetera that are experienced by members of groups targeted by racism, heterosexism, ageism, ableism, sexism, and other forms of oppression, and groups impacted by poverty (VAWnet). This training identifies and explores: the definition of this trauma; some of its possible impacts; points of how the field has been, is, and might be, part of the problem - and has been, is, and might be, part of the solution and healing; and ideas to develop/expand a personal plan to address insidious trauma in your work.

Trainer and contact:

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Agenda:

9:00 - 10:30	**Insidious Trauma -** Definition and some of its possible impacts
	The field and insidious trauma – part 1/2 - Past/present examples of the field and insidious trauma
10:30 - 10:45	**Break**
10:45 - 12:15	**The field and insidious trauma – part 2/2**
	Ideas to develop/expand plans to address insidious trauma

Disclaimers and disclosure:

- Any sources used are not endorsements of the source.
- As recognized, information is what it is, and may be constantly evolving.
- Training and materials are provided for informational purposes only.
- I am the originator and Director of the Connect All initiative, which has 501c3 fiscal sponsorship by We, the World.

Norms and Expectations:

Safe, and thus brave, space

Trainer: Trying to model; Self-care; Respect of others, any sharing; Fluid structure; I might, probably will, fail – how do we keep learning and in relationship when I do; Work with you as a community

Group: Self-care; Respect of others, any sharing; Be present and engaged as possible; Learn in what way works for you; Be part of community

Self-Care:

- Since a focus on insidious trauma, some of the material we cover may create responses in our bodies, behaviors, thoughts, and emotions.
- Even if it wasn't about trauma, we all have internal and external factors, creating responses in our bodies, behaviors, thoughts, and emotions*. *There are situations, such as with alexithymia, where individuals truly aren't going to have, experience, identify emotions the same as others do.
- Whatever works for you
- Apps and approaches section pp 6-9
- Help lines/links, apps, approaches PDF – Connect All
- Mindful moments: 30 seconds. Whatever works for you. May help with retention of information and self-care.

Apps and approaches

Apps:

NOTE: Some things to consider when using hotlines or mental health/wellness apps/online services.

- How do they protect my privacy? Are there steps I can take to protect my privacy?
- Are they ethical in their practices?
- What is the benefit/cost/risk of using them?

PTSD Coach (https://mobile.va.gov/app/ptsd-coach): By the Veterans Administration, is for anyone experiencing Post Traumatic Stress, or wanting to know more to help someone else.

WYSA stress: Depression & anxiety therapy chatbot app (has free option).

Moving forward (https://www.veterantraining.va.gov/movingforward/): By the Veterans Administration, is for anyone coping with stressful problems.

Woebot - Your Self-Care Expert (https://woebothealth.com/): Helps with an array; everyday stresses and challenges, symptoms of depression and addiction.

Mindfulness: Headspace, Insight Timer, Mindfulness Coach, 10% Happier

Other: ACT coach, Virtual Hope Box, CALMapp

Techniques:

NOTE: Not all techniques work for everyone. And if one works one time, it might not work another time; and vice versa, it might not work then work later.

Mental – Physical – Soothing Grounding, Healthline: 30 Grounding Techniques to Quiet Distressing Thoughts (https://www.healthline.com/health/grounding-techniques)

A few examples:

Mental: Pick a category (e.g., state capitals, teams, movies, bodies of water) and list as many as you can; or, list them alphabetically or by some system (e.g., largest to smallest, oldest to newest). Do math exercises. Go through anchoring facts (e.g., my name is, today is).

Physical: Touch something. Breathing exercise. Physical activity. Use your 5 senses.

Soothing: Think of face/voice/thing/place that soothes you. Talk yourself kindly through it. List positive things.

5-4-3-2-1 practice- In your mind, out loud, or written:

- 5 things I can see
- 4 things I can touch
- 3 things I can hear
- 2 things I can smell
- 1 thing I can taste

SOS Technique, developed by Julian Ford:

- Slow down - Slow down or stop; as needed, connect to body and let mind clear.
- Orient - Pay attention to where you are, what you are doing, who you are with, what's important.
- Self-check: How stressed or calm you are in the moment *and* how in control or dysregulated you are.

Breathing techniques: There are so many options, here's two examples.

- *Box breathing:* Exhale to a count of four. Hold your lungs empty for a four-count. Inhale to a count of four. Hold the air in your lungs for a count of four. Exhale and begin the pattern anew.
- *Mindful breathing*: Example, breathe in and out to a phrase, e.g. "I breathe in calm, I breathe out tension."; "Breathing in, I know I am breathing in. Breathing out, I know I am breathing out". Video**:** Mindful Breathing Exercise from Every Mind Matters – YouTube

Example other approaches:

- **Thoughts:** Check for value alignment. Check for accuracy. Replace them. Let go. Think about or do something else. Express them (e.g, journal). Do something creative/meaningful. Make a plan. Talk to someone.
- **Do a blend of mindfulness and physical**. While stretching, walking, so on: What's the closest/farthest sound I hear? What's the closest/farthest thing I see? What's the loudest/quietest sound? How relaxed/tense? So on.
- **Relax physically and mentally**. Slump, stretch out, curl up, let your mind empty, let your mind wander…
- **Do something physical with an empty mind**. As needed, maybe focus on the movement or your breath.
    - These stretches may be good for times like mini breaks: 4 Quick Stretches to Do If You've Been Sitting in the Car for Hours (https://www.self.com/gallery/sos-stretch-long-car-ride)
- **Do something physical while doing something verbally fun/silly/expressive**. E.g., Sing, talk nonsense, recite poetry, make weird sounds, do vocal exercises, mash up stories.

30 second body scan meditation:

This 30-Second Exercise Can Reduce Your Anxiety Significantly (It's True – We've Tried!)

(https://youaligned.com/body-scan-meditation/)

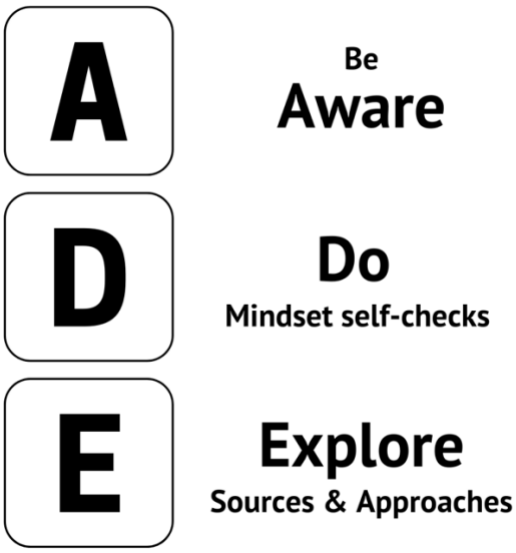
1. Get comfortable
2. Find your breath
3. Become the observer
4. Notice even more
5. Give yourself permission to relax

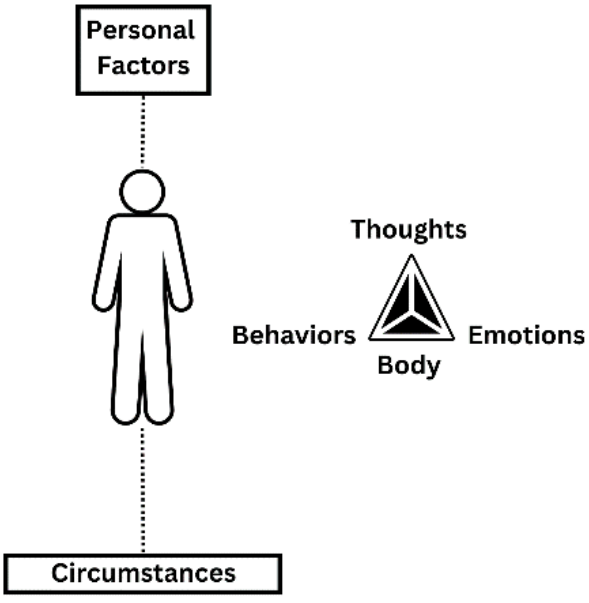
SC-ADE (adapted SBNRR mindfulness practice with the ADE by Gwendolyn Downing):

This can be modified to your needs and time available:

Stop: Stop what you are doing, take the pause, give yourself space. If you need to, use external or internal cues to do this.

Center: Everyone is different. For some, you might skip this and go to "be Aware". For some, it is helpful to pay attention to your breath and take a moment to breathe in whatever way works for you. For others, you might need a different (like grounding) or combined approach. For anyone, you might need to try different approaches at different times.





be Aware of my body, behaviors, thoughts, emotions: Notice what is going on with your body, behaviors, thoughts, emotions. You are not judging yourself, just notice what is going on.

- **Body:** What's happening in my body, from the top of my head to my toes? Am I warm, cold; relaxed, tense; numb, stiff, achy; tired, wired; thirsty, hungry; have a headache; and so on?
- **Behaviors:** What are my behaviors? What are my behaviors communicating to myself or/and others about how I'm doing?
- **Thoughts:** What are my thoughts? Am I present? Thinking about something I'm excited about, something that is bothering me? Any change from my normal? Are they accurate? Line up with my values? So on.
- **Emotions:** What am I feeling? Calm? Happy? Stressed? Furious? Anxious? Need to escape? "Spaced out"? Disconnected? Withdrawn? Bored? Numb? Confident? Proud? Surprised? Embarrassed? Nervous? Indifferent? Envious? Compassionate? So on.

Do mindset self-check: Am I being unbiased, strength-based, empowering, trauma-informed, so on?

Explore possible sources, for what I am aware of in my body, behaviors, thoughts, emotions: Remember individuals in ecological systems; and interaction of body, behaviors, thoughts, and emotions. What is the possible source(s) for what I am aware of? Do I need any assistance to identify the source? Can I identify the source? Is it one or more? What's my best guess, if I can make one? What do I not know? So on. // Queries such as when, where, with who, circumstance(s), how often, when does it not happen.

Explore possible approaches for what I am aware of in my body, behaviors, thoughts, emotions

- Is there something I can do/try about the source?
- Is there something I can do/try about the response?
- Is there anything else I can do/try?

In situations the source(s) aren't known, while trying to determine that, the three questions are still valid. Depending, e.g., prompts: "What's helped you with something else in the past?" "What are some of your strengths or things you enjoy doing; can that help you with this?"

Things that work for me:

What is insidious trauma?

The Three Es of Trauma (SAMHSA, 2023)**:**

- Individual trauma results from an **Event**, series of events, or a set of circumstances
- that an individual **Experiences** as physically, mentally, or emotionally harmful or life threatening
- and that may have lasting adverse **Effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Insidious trauma:

The daily incidents of marginalization, objectification, dehumanization, intimidation, et cetera that are experienced by members of groups targeted by racism, heterosexism, ageism, ableism, sexism, and other forms of oppression, and groups impacted by poverty. (VAWnet, n.d.)

Some of the terms in Insidious trauma:

Marginalization: to relegate to an unimportant or powerless position within a society or group.

Objectification: to treat as an object.

Dehumanization: to deprive someone of human qualities, personality, or dignity; to subject. someone to inhuman or degrading conditions or treatment; to address or portray someone in a way that obscures or demeans that person's humanity or individuality.

Intimidation: to make timid or fearful; especially to compel or deter by or as if by threats.

Oppression: unjust or cruel exercise of authority or power.

Insidious trauma questions ©2022-2024 Gwendolyn Downing

Questions about possible experiences one might have had or/and are having:

Have you ever? (To the right) **Because of?** (Below)	Been afraid of what might happen (including what might not happen)?	Had others act in a way you didn't like (e.g., be mean, avoid you, not care)?	Experienced any other injury of any type (e.g., bad water, bad air, no food, bad food, not getting any type of care you need, disasters)?
How much money you don't/do have			
The color of your skin, or anything about your physical appearance, that others would identify as part of a racial/ethnic group(s)			
Where you live now or/and lived before			
You appear male, female, other			
You have, or look like you have, a disability (acknowledging the issues regarding the word "disability" for some ways it's used)			
Your age or the age you appear			
The way you dress or/and make your physical appearance, that would identify you as part of a group(s)			
What gender(s) you are sexually attracted to			
Other			

Reflection areas:

You

Individuals in your life

Others, including those you work with/for

Questions:

While going through the definition(s), what was something significant to you?

While going through the reflection, what was something significant to you?

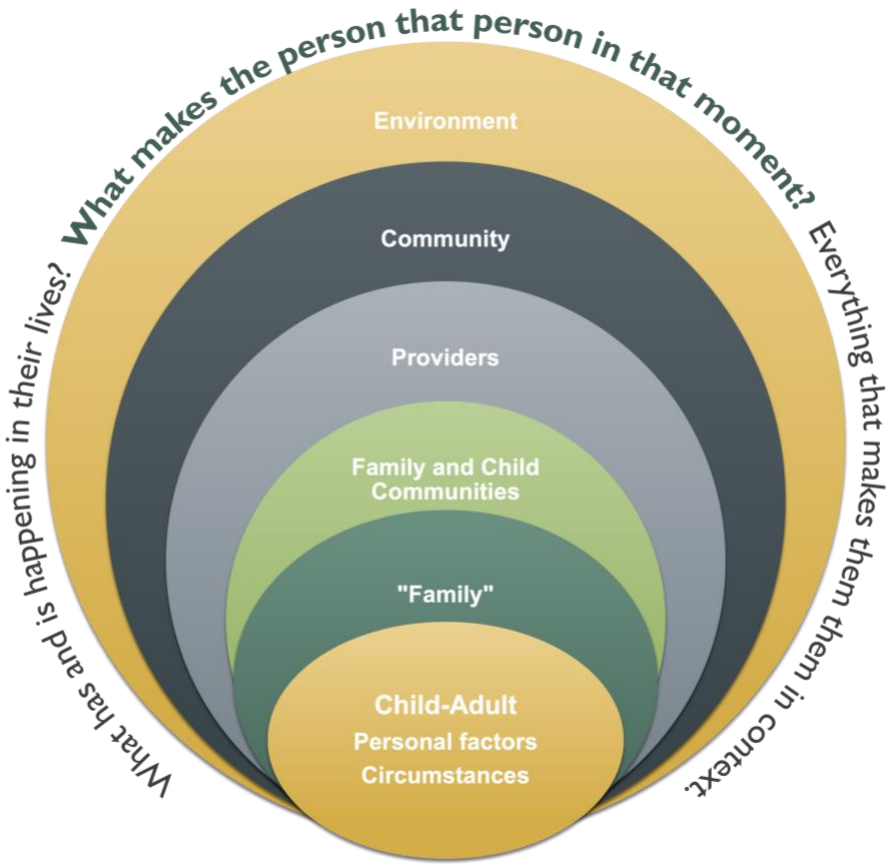
What is one way you think insidious trauma applies to your work?

Possible impacts of insidious trauma

Not everyone all the time:

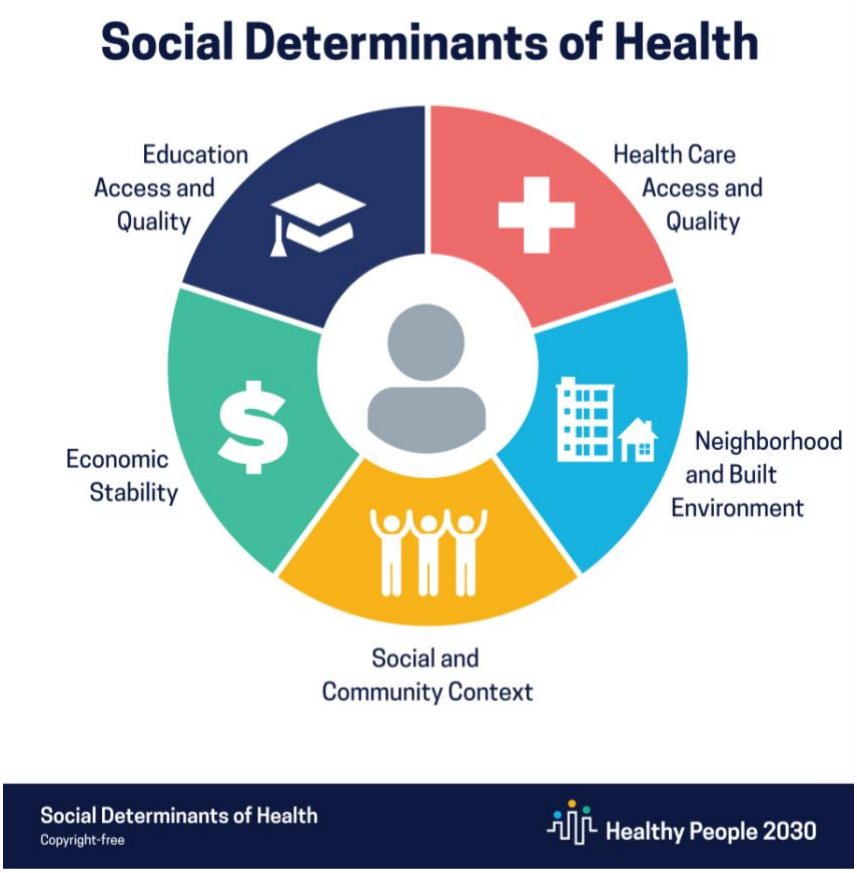
Everyone has their personal factors and circumstances; in which there are intrinsic, adaptive, and protective factors. And even if appears to be happening – trajectory isn't determination.

Who we are in context:



- Strengths
- Protective factors
- Historical trauma
- Inter-generational trauma
- Daily life stress
- Burnout
- Adversity
- Past or/and current trauma: Direct; Indirect; Acute; Chronic; Complex; Insidious; Collective/organizational/community; Vicarious; Secondary traumatic stress

Social Determinants of Health Example



https://health.gov/healthypeople/priority-areas/social-determinants-health

Examples of SDOH include:

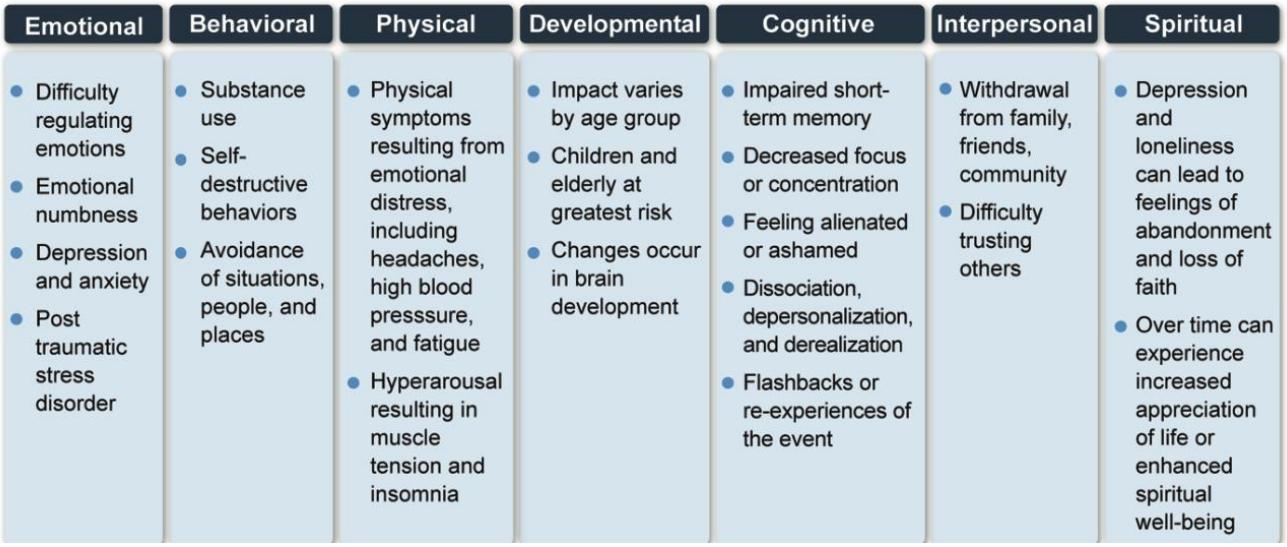
- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

Health – Mental health: access, quality, impact

Insidious trauma with the SDOH:

Insidious trauma, mental health, and SDOH:

Impact of Trauma on Individuals



Emotional	Behavioral	Physical	Developmental	Cognitive	Interpersonal	Spiritual
• Difficulty regulating emotions • Emotional numbness • Depression and anxiety • Post traumatic stress disorder	• Substance use • Self-destructive behaviors • Avoidance of situations, people, and places	• Physical symptoms resulting from emotional distress, including headaches, high blood presssure, and fatigue • Hyperarousal resulting in muscle tension and insomnia	• Impact varies by age group • Children and elderly at greatest risk • Changes occur in brain development	• Impaired short-term memory • Decreased focus or concentration • Feeling alienated or ashamed • Dissociation, depersonalization, and derealization • Flashbacks or re-experiences of the event	• Withdrawal from family, friends, community • Difficulty trusting others	• Depression and loneliness can lead to feelings of abandonment and loss of faith • Over time can experience increased appreciation of life or enhanced spiritual well-being

https://www.samhsa.gov/resource/ebp/practical-guide-implementing-trauma-informed-approach

Allostatic load:

Allostasis is the process by which the body responds to stressors to regain homeostasis. Allostatic load/overload is the related effects in the body, from repeat or chronic stress.

Original term from Bruce S McEwen and Eliot Stellar, 1993

Weathering:

Chronic exposure to experiences like racism, can lead to earlier health deterioration; both earlier health conditions (morbidity) and earlier death (mortality).

Original term from Arline Geronimus, 1992

Moral distress and secondary traumatic stress – insidious trauma

Adapted from: National Child Traumatic Stress Network's learning center: Cuellar, R., Hendricks, A., Clarke, M., Sprang, G., & the NCTSN Secondary Traumatic Stress Collaborative Group. (2021). Secondary Traumatic Stress: Understanding the Impact on Professionals in Trauma-Exposed Workplaces. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

Moral Distress

"Stress that occurs when one believes they know the right thing to do, but institutional or other constraints make it difficult to pursue the desired course of action."

Secondary Traumatic Stress (STS)

- Symptoms similar to, and at its most severe meet the criteria for, PTSD – from being indirectly exposed to another person's direct traumatic experience(s).
- Can impact children/youth and adults.

Moral distress, STS, and insidious trauma

- Connected to - my child, my child's friend, my partner, my friend, my colleague, etc
- Working with - any formal role, including volunteer

- The daily incidents of marginalization, objectification, dehumanization, intimidation, et cetera, experienced by those I'm connected to/work with, can create moral distress or STS.
- One may be both personally experiencing insidious trauma (outside of or/and at work)- as well as any moral distress/STS from those they're connect to/working with.
- If any part(s) of my identity/circumstance is part of the group that can experience insidious trauma, I may have additional vulnerabilities, such as:
    - Identification with individuals of a similar identity(ies) or with similar experiences.
    - Being asked/feeling compelled to contribute expertise about my marginalized identity(ies).
    - Having a greater load than others.
        - Higher workloads and being asked to take on additional responsibilities.
    - Work specific - Lack of safety or support in their agency.

Reflections:

- If experiencing insidious trauma outside/at work + moral/STS from insidious trauma -- possible impacts in creating safety for others?
- If experiencing moral/STS from insidious trauma -- possible impacts in creating safety for others?
- Think about _____, with either of the above -- possible impacts in creating safety?

Questions:

We Covered: Not everyone all the time; Context; Social Determinants of Health; Impact of trauma; Allostatic load; Weathering; Moral distress and secondary traumatic stress

One thing significant to you from what we covered?

Thoughts on how being aware of the possible impacts, can be a stressor?

Thoughts on how this ties to creating physical and psychological safety, for ourselves and others?

How much hope there is, in us doing better, as individuals and a society.

The Field and Insidious Trauma

The field and Insidious trauma - past and present:

The field has been, is, and might be, part of the problem. It has been, is, and can be, part of the solution and healing.

Quote: “Historically medicine in general, and also psychiatry, have looked at themselves as immune to the impact of society, and culture, as if unbiased and totally just trying to be scientific. But you see from the very beginning ways that people try to make sense of what they are seeing that are completely shaped and informed by the ways in which the world is biased.” Angela Coombs Psychiatrist; clip from PBS’s Mysteries of Mental Illness – Hysteria (2021).

Examples:

Racism

Apology to People of Color for APA's Role in Promoting, Perpetuating, and Failing to Challenge Racism, Racial Discrimination, and Human Hierarchy in U.S. - Resolution adopted by the APA Council of Representatives on October 29, 2021; History of Racism in American Psychology PowerPoint deck.

Summary of Harms

The historical review indicates that psychologists have, in both the past and present:

- Established and participated in scientific models and approaches rooted in scientific racism
- Created, sustained, and promulgated ideas of human hierarchy through the construction, study, and interpretation of racial difference
- Promoted the idea that racial difference is biologically based and fixed
- Used psychological science and practice to support segregated and subpar education for people of color
- Created and promoted widespread use of psychological tests and instruments that discriminated against people of color
- Failed to take concerted action in response to calls for an end to testing and psychometric racism
- Supported the widespread use of educational assessments and interventions that were lucrative for the field of psychology, but harmed people of color
- Provided ideological support for and failed to speak out against the colonial framework of the boarding and day school systems for First Peoples of the Americas
- Created, sustained, and promoted a view of people of color as deficient or damaged
- Applied psychological science and practice to oppose "race-mixing" and to support segregation, sterilization, and antimarriage laws, using the ideas of early 20th century eugenics
- Failed to represent the approaches, practices, voices, and concerns of people of color within the field of psychology and within society

- Failed to respond or responded too slowly in the face of clear social harms to people of color

Thoughts?

Thoughts about how this applies to your work?

How might points included in this summary, similarly apply to other groups impacted by insidious trauma?

Mental Illness - Experimental Treatments and Eugenics

MYSTERIES OF MENTAL ILLNESS: Experimental Treatments and the Rise of Eugenics:
Description: By the early 20th century, mental asylums had become extremely overcrowded, and very little was known about how to treat these patients. Out of view from the public eye, desperate doctors experimented with new treatments. When treatments failed, patients were labeled biologically defective, fueling the Eugenics program, and the involuntary sterilization of thousands of patients."

Quote: "It's important to understand, that the people doing these things, were very often true believers in what they were doing. They sincerely thought that their interventions, were therapeutic and well-motivated." Andrew Scull – Historian

Thoughts?

Eugenics included other groups within the insidious trauma groups

1914: Psychologist Henry Goddard, a pioneer of the U.S. testing movement, serves as the psychology representative on the Committee to Study and Report on the Best Practical Means of Cutting Off the Defective Germ-Plasm in the American Population. The Committee, established by the Research Committees of the Eugenics Section of the American Breeders Association, recommended segregation, and sterilization as the best methods of preserving "the blood of the American people" (Laughlin, 1914, p. 6). The Committee called on psychology to help determine standards and tests for identifying "mental degenerates and defectives proposed for sterilization" (p. 7). By 1930, 35,000 people in the U.S. had been sterilized, mostly individuals who had been deemed "feebleminded" or socially or mentally unfit (Greenwood, 2017). **Many of these individuals were immigrants, Black people, First Peoples of the Americas, poor White people, and people with disabilities** (Kevles, 1998). (APA's History of Racism in American Psychology).

Thoughts about impact on your work?

Heterosexism

American Psychiatric Association. (n.d.) Best Practice Highlights: Lesbian, Gay, Bisexual, Transgender and people who may be questioning their sexual orientation or sexual identity (LGBTQ). Prepared by Robert Paul Cabaj, M.D.

DSM-I (1952) – Homosexuality is listed as a sociopathic personality disturbance.

DSM-II (1968) – Homosexuality continues to be listed as a mental disorder

DSM-II (1974) – Homosexuality is no longer listed as a category of disorder. The diagnosis is replaced with the category of "sexual orientation disturbance".

DSM-III (1980) – The diagnosis of ego-dystonic homosexuality replaces the DSM-II category of "sexual orientation disturbance." Introduces gender identity disorder.

DSM-III-R (1987) – Ego-dystonic homosexuality is removed and replaced by "sexual disorder not otherwise specified," which can include "persistent and marked distress about one's sexual orientation."

DSM-V (2013)– Includes a separate, non-mental disorder diagnoses of gender dysphoria to describer people who experience significant distress with the sex and gender they were assigned at birth.

Eugenios, J. (May 2, 2022). 'I am a homosexual. I am a psychiatrist': How Dr. Anonymous changed history. NBC News. https://www.nbcnews.com/nbc-out/out-news/-homosexual-psychiatrist-dr-anonymous-changed-history-rcna26836

Ableism

The CDC's current estimated prevalence of disability for adults is "Up to 1 in 4 (27%)".

The field's role in:

- Creating/perpetuating in general population.
- Discrimination in the field, tied to research, screening, assessment, treatment.
- Discrimination in the field towards those working within the field or trying to.
- Impacting the whole system of care, such as in access to and set up of services.

Sexism:

American Psychological Association Committee for Women in Psychology (2004). *52 Resolutions and Motions Regarding the Status of Women in Psychology: Chronicling 30 Years of Passion and Progress.* https://www.apa.org/pi/women/resources/reports/52-resolutions.pdf

"In 1969, during the height of activism, APA members frustrated over the sexism, and lack of sensitivity and representation within the association, formed the Association for Women Psychologists (AWP). Women were discouraged from graduate programs in psychology by listings that stated "MEN PREFERRED (Exhibit 1);" professional meetings continued to be scheduled in locations and establishments that discriminated against women; and women were greatly underrepresented on APA's boards and committees - very few members were women. In 1970 members from AWP presented a historic list of 52 resolutions that dealt with employment, education, child and health care facilities, psychological theories and practice, conventions, equity in decision-making, and the general status of women."

Chrisler, J. C., & Smith, C. A. (2004). Feminism and psychology. In M. A. Paludi (Ed.), *Praeger guide to the psychology of gender* (pp. 272–291). Praeger Publishers/Greenwood Publishing Group. https://psycnet.apa.org/record/2004-21898-013

ABSTRACT: Feminism and psychology have a history of mutual influence. For example, sexist theories that were developed and promulgated by psychologists and psychiatrists were among the first targets of feminist activists in the second wave of the women's movement. Classic

feminist books took aim at Sigmund Freud, Erik Erikson, and other male psychologists and psychoanalysts whose theories described the psychology of women in ways that justified, as well as maintained, a power imbalance in favor of men. One might say that sexism in psychology was one of the sparks that ignited the women's liberation movement. The women's movement, in turn, had an enormous influence on women psychologists and psychology students. Excited by consciousness-raising groups and inspired by feminist political activism, many women psychologists and psychologists-to-be labeled themselves feminists and set out to make changes that would alter the direction of psychological science, practice, and training. It is the influence in this direction from feminism to psychology that will be the focus of this chapter.

Summary

Insidious trauma:	**The field's role in:**
The daily incidents of marginalization, objectification, dehumanization, intimidation, et cetera that are experienced by members of groups targeted by ▪ racism, ▪ heterosexism, ▪ ageism, ▪ ableism, ▪ sexism, ▪ and other forms of oppression, ▪ and groups impacted by poverty	▪ Creating/perpetuating in general population ▪ Discrimination in the field, tied to research, screening, assessment, treatment ▪ Discrimination in the field toward those working within the field or trying to ▪ Impacting the whole system of care, such as in access to and set up of services

The field's role in:
▪ Solutions and healing

What are some of your examples of the field and insidious trauma?

Question:
What is one way you think the issues of the mental health field and insidious trauma, applies to your work?

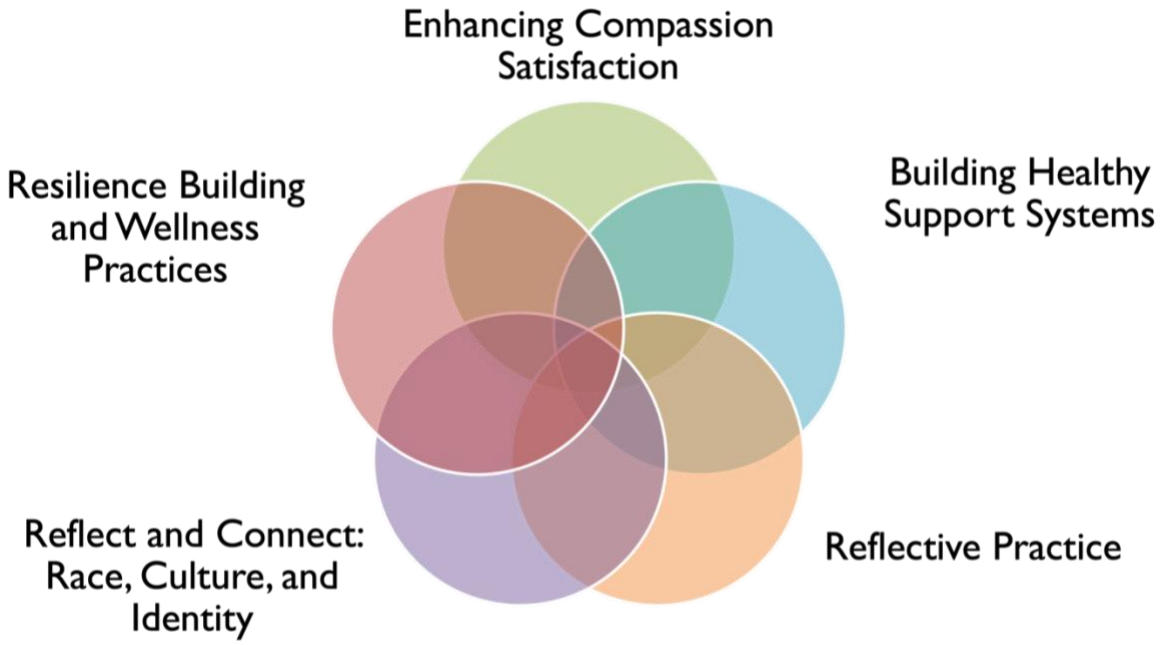
Develop/expand plans to address insidious trauma

Focuses:

- Self-care and secondary traumatic stress
- As a person and any role(s) one might have
- Clinical specific – if non-clinical, as needed for yourself or others

Optional resource share, QR code or/and link to Google doc:

Example of "Recommended strategies to mitigate STS" from NCTSN



Enhancing compassion satisfaction:

We all have bad days at work, but there are also moments that remind us why we do this work.

- Think about a rewarding moment at your job.
- What are 3 things that you love/enjoy about your job?
- Think about 5 people whose lives you've touched.
- Why did you take your current job?
- What are 3 compliments you have received from your co-workers, or 3 things you think you do well?

Building healthy support systems:

- Form or attend a process/consult group.
- Ask to take a walk and/or debrief with a co-worker.
- Leave a note of gratitude for a co-worker.
- Give a compliment or praise for a job well done.

- Share “moments of grace & goosebumps” with your team.
- Eat lunch together, go for a coffee/tea break, or bring snacks to a meeting.
- Tell a joke/funny story or show photos to a co-worker.

Reflective practice:

- What are your most salient signs and symptoms of work distress? When are you most likely to notice these come up, and when could you take stock on a regular basis?
- What client encounters or histories/stories tend to bring up strong emotions and reactions in you? How might this connect to your own history, family norms, or personal vulnerabilities? How might this influence or change your interactions with clients/situations that tend to activate these “hot or soft spots” for you? What has helped you to respond effectively in the past?
- What emotions tend to be most difficult for you to feel during the work day (with clients or co-workers)? How might this relate to the way emotions were handled in your own family of origin (e.g., which emotions were “allowed” or not) or from other key influences?

Reflective practice with co-workers, low-impact debriefing:

- Have conversations in private.
- Engage in Low-Impact Processing with co-workers when you feel stuck or ruminative.
    1. Self-Awareness
    2. Fair Warning
    3. Consent
    4. Limited Disclosure (avoid “**sliming**” your co-workers!)
- Refrain from one-upmanship when describing trauma or workplace stressor stories.

Reflect and Connect: Race, Culture, and Identity

Consider your own identities. How do your identities influence…

- …the way you see the world?
- …the way you see your work?
- …the way you understand the children and families with whom you work?

Check in with yourself…

- When you think about your work and your community, how do you feel?
- How do factors related to your identities contribute to your resilience and/or your experience of STS?
- Do you have someone to talk to about how you are feeling?

Connect with others to build mutual support around how your identities, cultures, race, and history may affect your responses to your work.

- Informal, supportive discussions with peers
- Regular peer processing groups
- Peer support and/or mentorship outside of your organization

Seek out and participate in traditional, cultural, and community healing, ceremonies, and supports.

Be honest and real about current injustices and challenges while also holding space for idealism, hope, and building change for future generations.

Examples for as a person and any role one might have

- **Start with ourselves** - Examine own biases, blind spots, behaviors, so on -- Even if you are experiencing insidious trauma, there might be areas you unknowingly contribute.
- **Include a lens of** "How might insidious trauma be a source/contributing source to what this individual is experiencing/exhibiting?" Also, the personal application.
- **Practice the best self-care we can** - Learn more about self-care, including ways to mitigate STS; Be more intentional; Reach out for help, as safe to do so.
- **Learn more about the issue**
- **Create awareness** – help others understand the issue, possible impacts, and things to do.
- **Advocate for change** – if possible, search for partners who are already doing advocacy work, and team up for greater impact.
    - Consider your role in where the field/profession is going.
- **Incorporate into the work you are already doing** – e.g., part of a group, such as parent, neighborhood, business, so on; or you're part of a specific initiative, like trauma informed change or DEI/similar efforts.
- **Safety** - Think of insidious trauma's interplay with creating physical and psychological safety in Environment, Practice, and Policy – home, business, neighborhood, system, field of work, agency, role(s), so on
    - **Question** – What insidious trauma sources are present in our (fill in the blank)? What is the evidence based, based on?
    - **Role(s)** – presentations/trainings, administration, research, supervision, so on
    - **Set up** – location, hours, costs, languages, honoring distrust of systems – and system created biases against receiving services
    - **Accessibility** – physical set up, materials
    - **Pragmatics** – transportation, child-care
    - **Culture** – self-care, supportive, interactions with colleagues

Examples for clinical

- **Intakes:** Are you incorporating anything about insidious trauma?
- **Screening and assessments:**
    - In general, are they appropriate for your client? Is how they are administered?
    - Are you incorporating anything about insidious trauma?
    - How do you respond to mistrust of diagnoses?
- **Diagnosing:** How might both sources and impact of insidious trauma impact diagnosing? Concerns with over, under, or mis diagnosing?
- **Treatment:**
    - TF-CBT example: TF-CBT and Racial Socialization Implementation Manual; TF-CBT IDD Implementation Guide and Supplemental Resource Guide; TF-CBT LGBTQ Implementation Manual; Culturally Modified-Trauma-Focused Cognitive Behavioral Therapy (CM-TFT) for Hispanic and Latino; Honoring Children, Mending the Circle: Cultural Adaptation of Trauma-Focused Cognitive-Behavioral Therapy for American Indian and Alaska Native Children
- **Documentation:** Are you including biases? What language are you using?
- **Resources for clients:** Such as handouts for their primary care or/and other providers.

Plan

What is one thing you are going to do/thinking about doing - new, more, or differently?

Ideas for planning:

- List things you know to do/try; what you might need to do it; when you'll do it; how you'll know if it works.
- List things you want to learn more about, where/who you can access to learn more about them, and when you'll do it.

Closing:

The Monkey Business Illusion, Daniel J. Simons – YouTube
(https://www.youtube.com/watch?v=IGQmdoK_ZfY)

What are we missing with insidious trauma?

- Blind spots for what is known
- What are some sources of insidious trauma, “we” might not recognize yet?

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Appendix A: Sources for self-care and secondary traumatic stress

CalTrin (California Training Institute) (https://www.caltrin.org/)

- **CalTrin Self-Paced Courses**
  - Understanding Compassion Fatigue and Secondary Traumatic Stress
  - Strategies for Addressing Compassion Fatigue and Secondary Traumatic Stress
- **CalTrin Training Archive**
  - Secondary Traumatic Stress and Reflective Practice/Supervision
  - Trauma, Compassion Fatigue & Secondary Traumatic Stress
  - Organizational Strategies: Addressing Compassion Fatigue & Secondary Traumatic Stress

Secondary Traumatic Stress Consortium – free resources
(https://www.stsconsortium.com/free-resources)

Secondary Traumatic Stress: Understanding the impact on professionals in trauma exposed workplaces - NCTSN Learning Center (https://learn.nctsn.org/)

Southern Regional Children's Advocacy Center – Secondary Traumatic Stress Resources
(https://www.srcac.org/reflect-refuel-reset/)

University of Kentucky Center on Trauma and Children's Secondary Traumatic Stress Innovations and Solutions Center (https://ctac.uky.edu/projects-and-programs/secondary-traumatic-stress-innovations-and-solutions-center-sts-isc)

- Staying Inside the Window of Tolerance: An Advanced Training on Secondary Traumatic Stress and Resiliency

Using the Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision - NCTSN (https://www.nctsn.org/resources/using-secondary-traumatic-stress-core-competencies-trauma-informed-supervision)

Virtual Calming Room - Sacramento City Unified School District (https://calmingroom.scusd.edu/): Has strategies and tools for students, families, and staff.

NOTE: Some things to consider when using hotlines or mental health/wellness apps/online services.

- How do they protect my privacy? Are there steps I can take to protect my privacy?
- Are they ethical in their practices?
- What is the benefit/cost/risk of using them?

Appendix B: Sources for trauma-informed approaches

Physical and psychological safety in Environment, Practice, and Policy

Trauma-Informed Approaches

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach 2014 (https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884) This manual introduces a concept of trauma and offers a framework for becoming a trauma-informed organization, system, or service sector. The manual provides a definition of trauma and a trauma-informed approach, and offers 6 key principles and 10 implementation domains.

SAMHSA's Practical Guide for Implementing a Trauma-Informed Approach 2023 (https://www.samhsa.gov/resource/ebp/practical-guide-implementing-trauma-informed-approach) This practical guide updates and expands the discussion presented in SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach Resource from 2014. The primary goal of this guide is to provide implementation strategies across multiple domains based on the original publication.

Considerations

Older Adults' Equity Collaborative's *Equity Assessment Checklist* (https://resourcelibraryadmin.nyam.org/resource-library/oaec-equity-checklist/)
This equity self-assessment aims to help agencies determine how effectively they are supporting communities of greatest social need (GSN). It also aims to aid in identifying areas of growth. To get started, mark the boxes next to the actions your agency or team is taking to be more inclusive to this range of service recipients. Please note that this is not an all-encompassing list of items necessary to serve GSN clients in your communities. Communities of Greatest Social Need (GSN) include: Black; Latino; Indigenous and Native American; Asian American and Pacific Islander; other persons of color; members of religious

minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; and persons who live in rural areas.

SAMHSA TIP 59: Improving Cultural Competence (https://www.samhsa.gov/resource/ebp/tip-59-improving-cultural-competence)

United Spinal Association's Disability Etiquette, Tips On Interacting With People With Disabilities (https://www.unitedspinal.org/pdf/DisabilityEtiquette.pdf)

Appendix C: Sources for clinical

Being Informed, Screening, Assessment, and Treatment

The following has a mix for being informed, screening, assessment, or/and treatment.

Anthropology in the clinic: the problem of cultural competency and how to fix it. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1621088/) This approach isn't always appropriate, it's just one to be aware of if needed.

APA *Guidelines for Assessment and Intervention with Persons with Disabilities* (https://www.apa.org/pi/disability/resources/assessment-disabilities).

Improving Cultural Competency for Behavioral Health Professionals – HHS course (https://thinkculturalhealth.hhs.gov/education/behavioral-health) "Learn how to better respect and respond to your client's unique needs in this free, online training." Has free CEs.

Mental Health, Trauma, and Disability – Children/Youth: Three documents to supports a child or youth with a developmental delay or/and a disability who has experienced trauma. These documents are for caregivers, mental health providers, and others. Gwendolyn Downing.

Intakes

Polyvictimization Assessment Tool and Resource Guidebook

This is a **non-diagnostic** tool that was created through the Office for Victims of Crime. It is available in English, Spanish, Russian, and gender-neutral versions. The below resources and more are available from the Family Justice Center Alliance (https://www.familyjusticecenter.org/)

- Polyvictimization Assessment Tool – English Version: The Polyvictimization Assessment Tool (Assessment Tool) was developed to examine a survivor's entire life experience of trauma and victimization, from childhood to adulthood. The Assessment Tool covers 27 events and 18 sections, each broken down into three categories (Child and Teen, Adult, In the Last Year). The symptoms category allows staff to triage current symptoms and allows for a deep historical understanding of when these symptoms developed and how long they have been present in the survivor's life.
- Polyvictimization Assessment Tool Resource Guidebook: Created by the Alliance, under the Creating Pathways to Justice, Hope, and Healing Polyvictimization Demonstration Initiative, this Guidebook is designed as a 'how-to' for frontline staff implementing the Polyvictimization Assessment Tool. This Guidebook is a reference for staff and Centers before they ever utilize the Tool with a survivor. This Guidebook also contains an appendix of resources by national experts on the categories of trauma and symptomology as well as the Polyvictimization Assessment Tool in English, Spanish, and Russian.

Screening and assessments

Oklahoma TF-CBT Resources & Information for Working with Diverse Populations
(https://oklahomatfcbt.org/resources-information-for-working-with-diverse-populations/)

- Assessing PTSD in Racial Ethnic Minorities

Treatment

SPARCS

Structured Psychotherapy for Adolescents Responding to Chronic Stress
https://www.nctsn.org/interventions/structured-psychotherapy-adolescents-responding-chronic-stress

TF-CBT

Trauma-Focused Cognitive Behavioral Therapy National Therapist Certification Program

(https://tfcbt.org/)

- TF-CBT and Racial Socialization
- TF-CBT IDD Implementation Guide
    - Supplemental Resource Guide
- TF-CBT LGBTQ Implementation Manual

Culturally Modified-Trauma-Focused Cognitive Behavioral Therapy (CM-TFT) for Hispanic and Latino

- NCTSN CMTFT fact sheet
- NCTSN CMTFT culture specific fact sheet

Honoring Children, Mending the Circle: Cultural Adaptation of Trauma-Focused Cognitive-Behavioral Therapy for American Indian and Alaska Native Children

Oklahoma TF-CBT Resources & Information for Working with Diverse Populations

(https://oklahomatfcbt.org/resources-information-for-working-with-diverse-populations/)

- Adapting TF-CBT for American Indian and Alaska Native Children
- Adapting an Evidence Based Child Trauma Treatment for American Indian and Alaska Native Populations
- Webinar – Enhancing Healing Through the Incorporation of Familial Culture and Spirituality in TF-CBT
- Assessing PTSD in Racial Ethnic Minorities

Appendix D: Additional sources

This page is in development. Use space for shared resources during training.

Appendix: E Medical – Mental Health - Psychology

Medical – Mental Health – Psychology: A rough select timeline

Patient Care	
Beginning of the Hippocratic oath - multiple contributors	5th century BCE
Mental Hygiene to Mental Health	
The term "mental hygiene" first used	1843
Clifford Beers' book Founding meeting of the National Committee for Mental Hygiene	1908
First International Congress on Mental Hygiene	1933
Roughly official change to "mental health" 1946 - The International Health Conference decides to establish the World Health Organization (WHO); A Mental Health Association is founded in London 1948 – The WHO established; The first International Congress on Mental Health	1946 -1948
National Institute of Mental Health established	1946-1949
While there were prior orgs, SAMHSA established	1992
Field of Psychology	
Arguable. First experimental theory in Germany, 1854. First labs began in Germany and the US 1875-1879.	1854-1879

Organization	**Year founded**	**Year 1st ethics**
American Psychiatric Association	1844	1973
American Medical Association	1847	1847
American Psychological Association	1892	1952/53
American Personnel and Guidance Association (ACA)	1952	1961
American Bar Association	1878	1908
WMA -Declaration/International Code of Medical Ethics	1947	1948/1949
World Psychiatric Association – Declaration of Hawaii	1950	1977
Ethics regarding research and human subjects		
WMA - Declaration of Helsinki, human subjects	1947	1964
Nuremberg Code in 1948; Guidelines for Human Experimentation of 1931; Berlin code of 1900.	(Ghooi, et al, 2011)	1900-1948
National Research Act – Belmont Report		1974 -1979

Reminder: Having an ethical code, didn't/doesn't mean there were/are enforceable standards.

Appendix F: Gwen's TIDAL facilitation lens ©2024 - synopsis

Overview

To facilitate, loosely, is to bring something about, and do so as smoothly and effectively as possible. And whatever I'm doing, from beginning to end, I want to have a TIDAL facilitation lens:

- Trauma-informed
- Insidious trauma sources
- Diversity – Individuality
- Accessibility
- Life

Things I might facilitate

Parts of life. Meeting, presentation, training, moderating, consulting, materials, so on.

What I want to keep in mind as I plan, prepare, do, and follow-up

- **Trauma-informed:** Trauma-informed approaches for creating physical and psychological safety.
- **Insidious trauma sources[(1)]:** How the sources may/do impact my facilitation, and what I can do/try.
- **Diversity-individuality:** One person or a multitude, there is all the possible diversity. And even in groups that have a fairly congruent culture, there is still individuality.
- **Accessibility:** The CDC's prevalence estimate is 1 in 4 adults have some kind of disability[(2)], the broader applicability, and accessibility considerations and practices.
- **Life:** There are the typical daily components of our lives that need to be considered, and that "life happens".

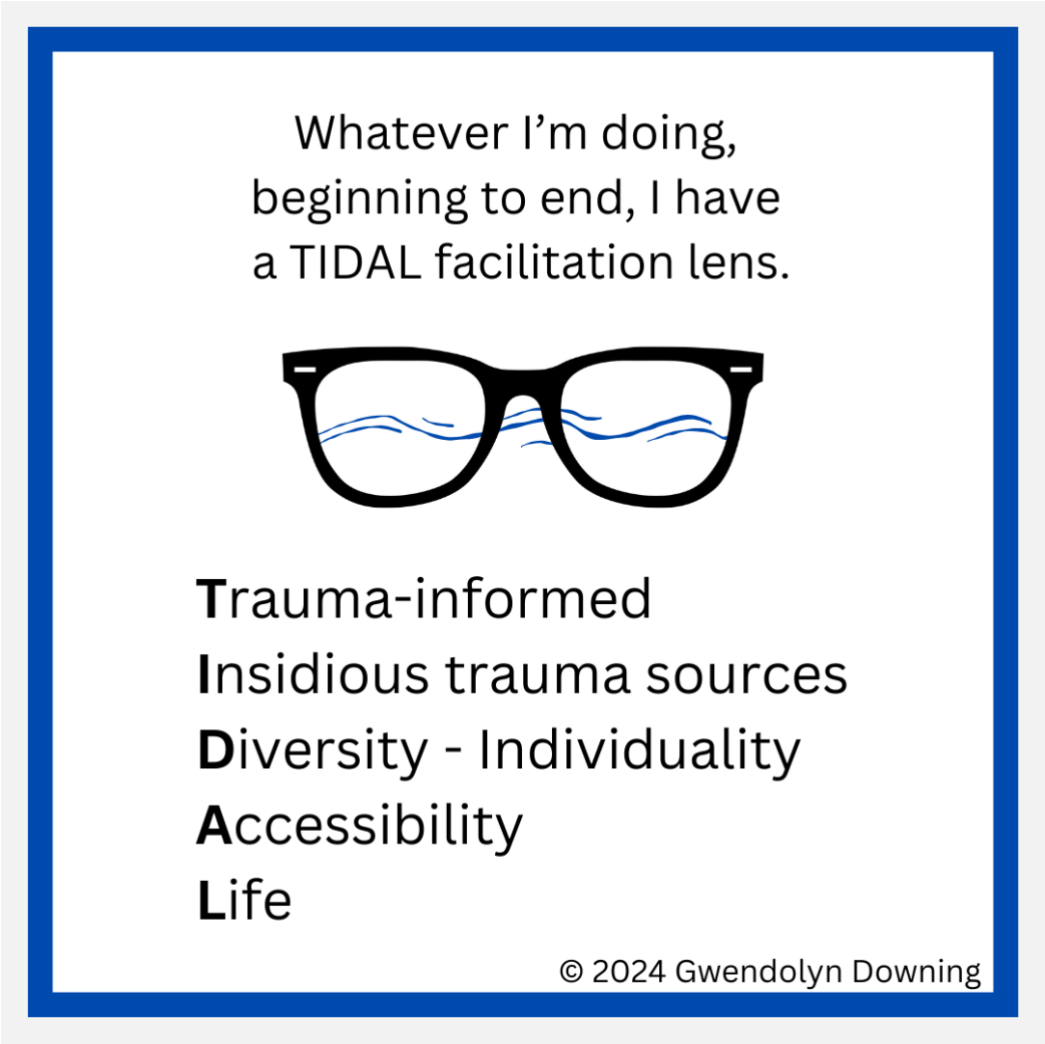
Why is the TIDAL lens important?

I start with values, such as outcomes, quality, connection; and then as applicable, standards, such as best practice, policies, 508.

I hope this inspires thoughts and dialogue

Possible next steps

Please use/share the image (downloadable on website) and this handout for personal use and small meetings. For any other use or/and trainings, train-the-trainer trainings, so on, contact me at Gwen@ConnectAll.online.



1- Insidious trauma Is the daily incidents of marginalization, objectification, dehumanization, intimidation, et cetera that are experienced by members of groups targeted by racism, heterosexism, ageism, ableism, sexism, and other forms of oppression, and groups impacted by poverty (VAWnet).

2- Use of the word "Disability" I understand the issues regarding the word "disability" for some ways it is used. I use it now and other times, as it is expedient.