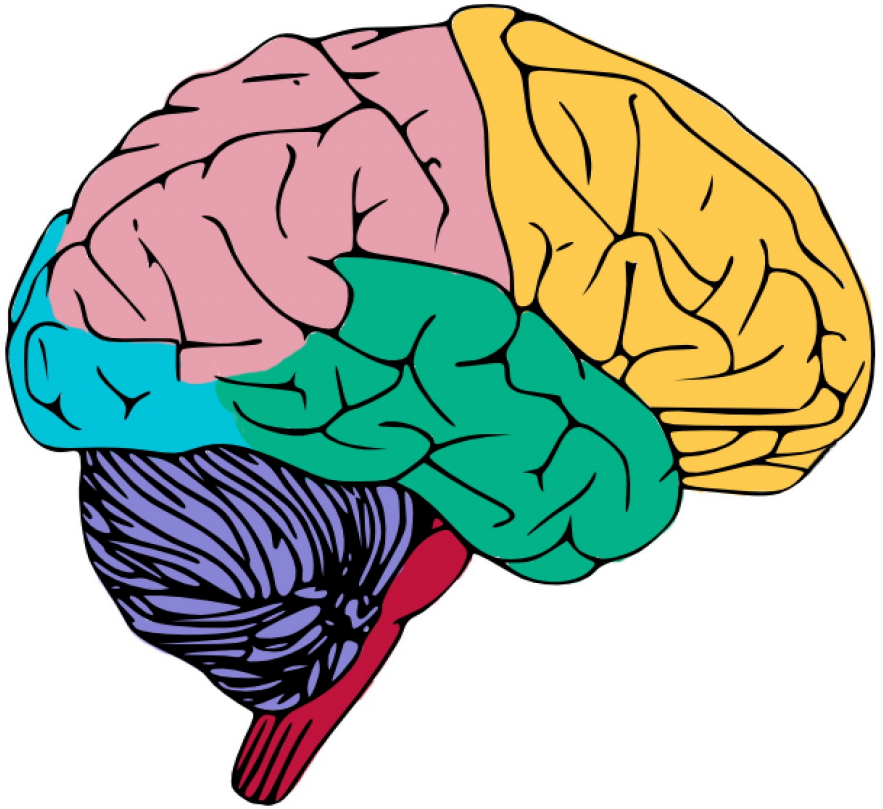
Trauma Informed Social Work

Module 2: Class 6

Practice Implications: Marginalized Communities Experiences of Community & Historical Trauma



Agenda

- Collective Trauma in Marginalized Communities
- Social Work Practice with Traumatized and Marginalized Communities

Historical, Collective & Mass Trauma

HISTORICAL TRAUMA

- **Background: Historical Trauma**
  - Appeared in literature among American Indians in 1995
  - Frames the lifespan trauma in the collective, historical context, which empowers Indigenous survivors of both communal and individual trauma by reducing the sense of stigma and isolation.

- Refers to "a **collective complex trauma** inflicted on a **group of people** who **share a specific group identity or affiliation-ethnicity, nationality, and religious affiliation**. It is the **legacy of numerous traumatic events** a community **experiences over generations** and encompasses the **psychological and social responses** to such events" (Evans-Campbell, 2008, p. 320)

- Historical trauma includes violations against land, including environmental contamination; dislocation and forced removal; and community massacres.
  - Events are perpetrated with malicious, "destructive intent" (Evans-Campbell, 2008, p. 321).

HISTORICAL TRAUMA

- Historical trauma (HT) = cumulative emotional & psychological wounding across generations, including the lifespan, which emanates from massive group trauma (Brave Heart, 2003, 1998).

- Historical Trauma Response (HTR) = constellation of features associated with a reaction to a massive group trauma.

- Long term goal of historical trauma intervention
  - Alleviate psychological suffering
  - Reduce emotional suffering among Indigenous peoples of the Americas
  - Developing culturally responsive interventions driven by the community to improve behavioral health.

COLLECTIVE/MASS TRAUMA

- Refers to “psychological reactions to a traumatic event that affect an entire society” Hirschberger, 2018)
- Was studied by Kai Erikson in relation to natural disasters
- In his assessment of collective trauma, he concluded it represents “***a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community***.” (Erikson, 1976)
- Robben, who studied the effects of political violence in Argentina, noted that “***collective trauma is a wound to the social body and its cultural fram***e.” (Robben, 2005, p. 346).

COLLECTIVE / MASS TRAUMA

- Mass trauma affects individuals' abilities to participate in social and political life by causing or contributing to:
  - Isolation, mistrust, suspicion, withdrawal
  - Deterioration of trust in moral order, justice, government entities, and democracy
  - Weakened ability of individuals to organize and work collectively

Adapted from Cindy Sousa's presentation on Community Trauma

IMPACT OF COLLECTIVE/ MASS TRAUMA ON COMMUNITY FUNCTIONING & SOCIAL FABRIC

Mass Trauma affects community functioning and social fabric in 2 main ways:

1. **Damage to shared physical location**
   - Mass killings or disappearances
   - Displacement and migration
   - Destruction of meaningful places
   - Control of space & movement

2. **Change in climate & functioning**
   - Instillation of collective fear
   - Destruction of social networks
   - Diminishment in number & strength of community organizing activities

Adapted from Cindy Sousa's presentation on Community Trauma

TRAUMA & CULTURE

1. Some populations and cultures are more likely than others to experience a traumatic event or a specific type of trauma

2. Rates of traumatic stress are high across all diverse populations and cultures that face military action and political violence

3. Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma

4. Some traumas may have greater impact on a given culture because those traumas represent something significant for that culture or disrupt cultural practices or ways of life

Content adapted from Dean J. Shapiro

TRAUMA & CULTURE

5. Culture determines acceptable responses to trauma and shapes the expression of distress. It significantly influences how people convey traumatic stress through behavior, emotions, and thinking immediately following a trauma and well after the traumatic experience has ceased.

6. Traumatic stress symptoms vary according to the type of trauma within the culture.

7. Culture affects what qualifies as a legitimate health concern and which symptoms warrant help.

8. In addition to shaping beliefs about acceptable forms of help-seeking behavior and healing practices, culture can provide a source of strength, unique coping strategies, and specific resources.

Content adapted from Dean J. Shapiro

TRAUMA & THE INEXORABLY LINKED PERSON-ENVIRONMENT RELATIONSHIP

- Well-being rests on the mutual exchange between a person and their environment (Bronfenbrenner and Morris, 1998).
- Foundations of mental health rest on relationships and collective ties that affirm ones' humanity (Martín-Baró, Aron, & Corne, 1994).
- Individuals and their social & political environments are mutually dependent (de Zulueta, 2007; Farwell & Cole, 2001; Hernandez, 2002).

Adapted from Cindy Sousa's presentation on Community Trauma

UNDERSTANDING THE LEVELS WITHIN THE SOCIAL-ECOLOGICAL MODEL OF TRAUMA AND ITS EFFECTS

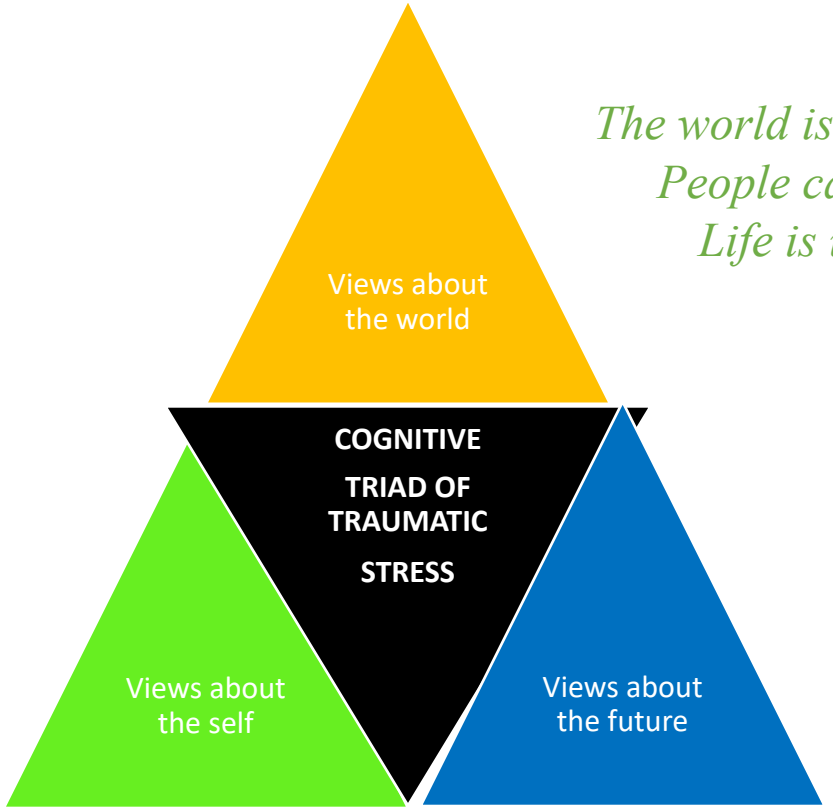
Individual factors	Interpersonal Factors	Community & Organizational Factors	Societal Factors	Cultural & Developmental Factors	Period of Time in History
Age, biophysical state, mental health status, temper ament and other personality traits, education, gender, coping styles, socioeconomic status	Family, peer, and significant other interaction patterns, parent/family mental health, parents' history of trauma, social network	Neighborhood quality, school system and/or work environment, behavioral health system quality and accessibility, faith-based settings, transportation availability, com munity socioeco-nomic status, community em-ployment rates	Laws, State and Federal economic and social policies, media, societal norms, judicial system	Collective or individualistic cultural norms, ethnicity, cultural subsystem norms, cognitive and maturational development	Societal attitudes related to military service members' home comings, changes in diagnostic understanding between DSM III-R* and DSM-5**

Source: Trauma-Informed Care: A Sociocultural Perspective, SAMHSA

SW PRACTICE WITH TRAUMATIZED & MARGINALIZED COMMUNITIES

COMMUNITIES

IMPACT OF TRAUMA: COGNITIVE TRIAD OF TRAUMATIC STRESS



The world is a dangerous place
People cannot be trusted
Life is unpredictable

I am incompetent
I should've reacted differently
It is too much for me to handle
I feel damaged

Things will never be the same
What is the point?
I will never get over this
It is hopeless

Source: SAMSHA, 2014

CLINICAL IMPLICATIONS – HISTORICAL TRAUMA

Both clients and providers can competently manage traumatic experiences and reactions

- Providers are interested in hearing clients' stories and attending to their experiences
- Recovery is possible
- Work with the client to learn the cues they associates with past trauma.
- Obtain a good history
- Maintain a supportive, empathetic, and collaborative relationship
- Encourage ongoing dialog
- Provide a clear message of availability and accessibility throughout treatment

TRAUMA-INFORMED PROVIDERS

- Trauma-informed providers *anticipate* and *respond* to potential practices that may be perceived or experienced as retraumatizing to clients
- They are able to *forge new ways to respond to specific situations that trigger a trauma-related response*
- They can *provide clients with alternative ways of engaging in a particularly problematic element of treatment.*

Source: SAMHSA

PRACTICE IMPLICATIONS

- Creating safety is not about ***getting it right all the time***; it's about how consistently and forthrightly you handle situations with a client when circumstances provoke feelings of being vulnerable or unsafe.
- Honest and compassionate communication that conveys a sense of handling the situation together generates safety.
- It is equally important that safety extends beyond the client!

- What information would be helpful for us to know about what happened to you?
- Where/when would you like us to call you?
- How would you like to be addressed?
- Of the services I've described, which seem to match your present concerns and needs?
- From your experience, what responses from others appear to work best when you feel overwhelmed by your emotions?

USING STRENGTHS-ORIENTED QUESTIONS

Knowing a client's strengths can help you understand, redefine, and reframe the client's presenting problems and challenges.

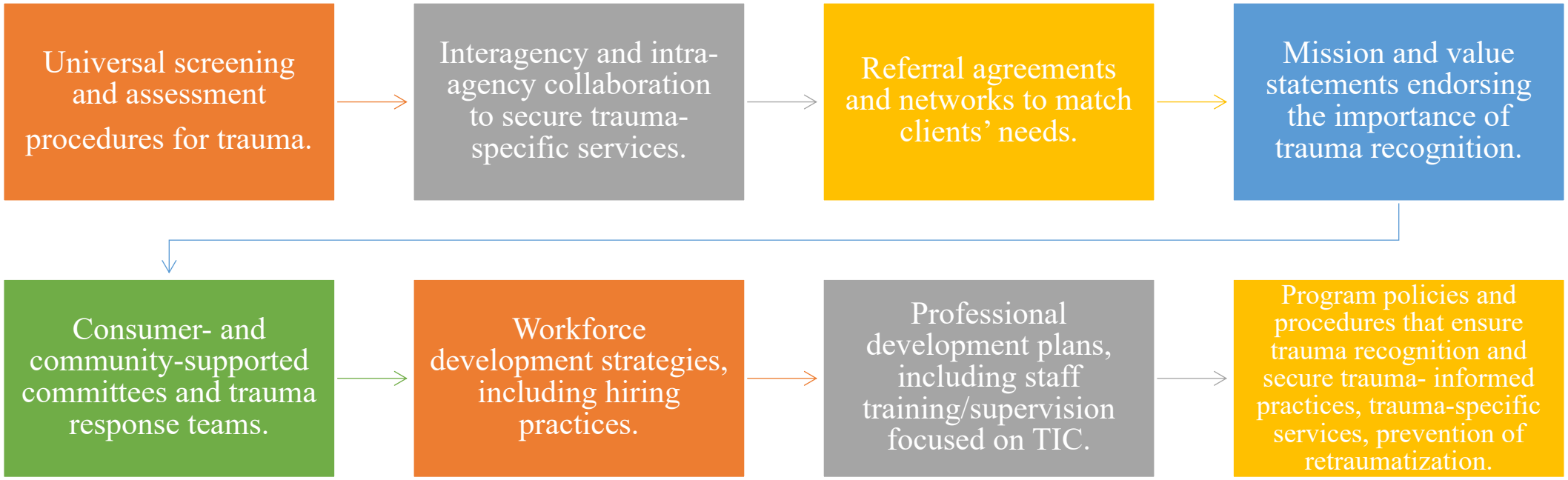
By focusing and building on an individual's strengths, counselors and other behavioral health professionals can shift the focus from "What is wrong with you?" to "What has worked for you?"

It moves attention away from trauma-related problems and toward a perspective that honors and uses adaptive behaviors and strengths to move clients along in recovery.

See strengths-oriented questions/approaches on Moodle

ORGANIZATIONAL COMMITMENT IN PRACTICE – SUPPORTING COLLECTIVE/MASS & HISTORICAL TRAUMA

Not just limited to therapist-client interactions – commitment of the organization, too!



Example: Chelsea Collaborative & Shanbaro Community Association

The Shanbaro Community Association was created by and supports the 400+ Somali Bantu refugees living in Chelsea and surrounding cities to build a strong community and to resolve significant quality of life issues.

Investing in refugee community

- **Employment, skill building, advocacy for services**
- **Refugee community has ownership of research and data – greater chance of sustainability**
- **Insider knowledge leads to higher quality of research**

https://www.la-colaborativa.org/about-6

Content adapted from Dean J Shapiro

HISTORICAL TRAUMA MEASURES TO INFORM CLINICAL & COMMUNITY-BASED PRACTICES

- Historical Loss Scale (HLS) & Historical Loss and Associated Symptoms (HLAS) (Whitbeck, 2004a)
- Indigenous Peoples of the Americas Survey (IPS)
- Historical Trauma and Unresolved Grief Intervention (HTUG)

Ways for Addressing Retraumatization

1. Anticipate and be sensitive to the needs of clients who have experienced trauma regarding program policies and procedures in the treatment setting that might trigger memories of trauma, such as lack of privacy, feeling pushed to take psychotropic medications, perceiving that they have limited choices within the program or in the selection of the program, and so forth.

2. Attend to clients' experiences. Ignoring clients' behavioral and emotional reactions to having their traumatic memories triggered is more likely to increase these responses than decrease them.

3. Develop an individual coping plan in anticipation of triggers that the individual is likely to experience in treatment based on his or her history.

4. Rehearse routinely the coping strategies highlighted in the coping plan. If the client does not practice strategies prior to being triggered, the likelihood of being able to use them effectively upon triggering is lessened. For example, it is far easier to practice grounding exercises in the absence of severe fear than to wait for that moment when the client is reexperiencing an aspect of a traumatic event. (For more information on grounding exercises, refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*; Najavits, 2002a, pp. 125–131.)

Ways for Addressing Retraumatization

5. Recognize that clinical and programmatic efforts to control or contain behavior in treatment can cause traumatic stress reactions, particularly for trauma survivors for whom being trapped was part of the trauma experience.

6. Listen for the specific trigger that seems to be driving the client's reaction. It will typically help both the counselor and client understand the behavior and normalize the traumatic stress reactions.

7. Make sure that staff and other clients do not shame the trauma survivor for his or her behavior, such as through teasing or joking about the situation.

8. Respond with consistency. The client should not get conflicting information or responses from different staff members; this includes information and responses given by administrators.

Small Group Activity (20 minutes)

- Using the vignette below respond to the questions about Nancy, Joseph, & Marisol.

Nancy

Nancy is a Mandingo sexual abuse survivor from Liberia who has been working in therapy for some time. Although she has processed the traumatic experiences of her past, she still struggles with the shame of rape. She feels isolated from her community of friends and depressed. When the therapist asks her about how women recover from these situations back home, she says, “Oh that’s easy. We have a ceremony for healing shame and welcoming women back into the community. The whole village of women go down to the river and perform a cleansing. Then the rape survivor is welcomed back into the village and their shame is healed. But I can’t do that here.”

1) **What would be a culturally sensitive response to strengthen the therapeutic alliance?**
2) **How might you address the impact of both trauma and diversity on her experiences of isolation and shame?**
3) **How might differences in culture, race, gender, age, class, and other aspects of identity and privilege affect the therapeutic process if you were the assessing therapist and this was your client?**

Joseph

Joseph was referred to you by the domestic violence program in town after assaulting his wife during a heated argument about who she can be friends with. He and his wife are from Sierra Leone and have only recently reunited with one another after a long separation while he was getting established in this country. When Joseph arrives in therapy, he is very upset, stating that "it is important for a man to have control in the household. You cannot expect me to change overnight what took your country hundreds of years to change. We are not like that. That is not our culture!"

1) **What would be a culturally sensitive response to address both trauma and diversity to strengthen the therapeutic alliance?**

2) **How might differences in culture, race, gender, age, class, and other aspects of identity and privilege affect the therapeutic process if you were the assessing therapist and this was your client?**

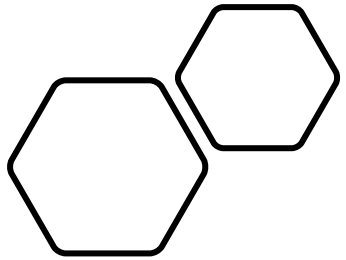
Marisol

Marisol is a 28-year-old Latina woman working as a barista at a local coffee shop. One evening, she was driving home in the rain when a drunk driver crossed into her lane and hit her head on. Marisol remained conscious as she waited to be freed from the car and was then transported to the hospital. She sustained fractures to both legs. Her recovery involved two surgeries and nearly 6 months of rehabilitation, including initial hospitalization and outpatient physical therapy.

She described her friends and family as very supportive, saying that they often foresaw what she needed before she had to ask. She added that she had an incredible sense of gratitude for her employer and coworkers, who had taken turns visiting and driving her to appointments. Although she was able to return to work after 9 months, Marisol continued experiencing considerable distress about her inability to sleep well, which started just after the accident. Marisol describes repetitive dreams and memories of waiting to be transported to the hospital after the crash. The other driver was charged with driving under the influence (DUI), and it was reported that he had been convicted two other times for a DUI misdemeanor.

1) **In what ways could Marisol's ethnic and cultural background influence her recovery?**
2) **What societal factors could play a role in the car crash itself and the outcomes for Marisol and the other driver?**

Food For Thought



“Avoiding your triggers isn’t healing. Healing happens when you’re triggered and you’re able to move through the pain, the pattern, and the story – and walk your way to a different ending.” (Unknown)