

# RESIDENTIAL SUBSTANCE ABUSE TREATMENT (RSAT)

Training and Technical Assistance

## Introduction to Trauma and Trauma-Informed Approaches for RSAT Staff

# Introduction to Trauma and Trauma-Informed Approaches for RSAT Staff

## Trainer’s Manual

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## Introduction

This cross-disciplinary training curriculum focuses on understanding trauma and its impact on people in criminal justice setting who have substance use disorders. It explains the principles and practices of trauma-informed approaches and offers support for implementing trauma-informed approaches in correctional settings. It is intended for Residential Substance Abuse Treatment (RSAT) program staff and for correctional staff who work with people participating in RSAT jail, prison, and aftercare programs.

The connection between trauma histories and behavioral health diagnoses—including substance abuse disorders—has been well-documented by research. This has led to the development of trauma-informed approaches in public and private behavioral healthcare systems. Research also documents the extent of trauma histories among people who are or have been incarcerated.

Given these findings, it is important that RSAT participants have access to trauma-informed approaches to services, supports, and treatment.

The goals of the curriculum are:

1. To increase knowledge about trauma, its impact, and its prevalence among people with substance abuse disorders and incarcerated individuals.
2. To increase knowledge about trauma-informed approaches and how they can benefit RSAT participants, increase institutional security, and decrease the need for costly interventions.
3. To provide practical tools for implementing trauma-informed approaches within the constraints of correctional settings.

## Preparation for Training

***This training was designed to be delivered as three separate 1.5- 2 hour modules that may be presented on different days.***

***But the curriculum is flexible and can be delivered in a variety of ways. For example, it can be presented as one full day of training: 9:00 a.m. to 4:00 p.m., with a 1-hour lunch break and 10- to 15-minute breaks in the morning and in the afternoon.***

***Or, the curriculum could be adapted and modified for shorter time periods by covering each topic as an overview and omitting some details, or by using only selected sections of the curriculum.***

In addition to having robust training skills, it is important that trainers have solid knowledge of trauma-related topics and self-awareness about trauma's impact on them. During training, trainers and participants may become emotionally affected by the material, so it is helpful to train in teams of two, both to support each other and to have a trainer available to assist participants if needed. By modeling trauma-informed practices during training, you can minimize or mitigate the negative impact of past trauma during training.

## **Modeling Trauma-Informed Practices in Training**

When training on topics related to trauma, it is important to use approaches that are rooted in an understanding of trauma-informed practices. In “Walking the Walk: Modeling Trauma Informed Practice in the Training Environment,”<sup>1</sup> Leslie Lieberman identifies the following principles and discusses how to demonstrate them in training:

- Creating safety
  - Ask participants to consider strategies for self-care they can use during the training.
  - When discussing traumatic events, give enough information to convey the idea but omit graphic details.
- Maximizing opportunities for choice and control
  - Let participants know they are free to choose not to participate in any activity.
  - Remind participants that they are free to move about the room or leave the room if they wish.
- Fostering connections
  - Provide opportunities for participants to interact with one another through small group or dyad discussions. In large auditoriums this can be facilitated by having discussions with a few people seated nearby. This does not require changing seats.
- Facilitating self-reflection and managing emotions
  - Build in opportunities to ask the group how they feel about a particular activity or piece of information.

Lieberman’s article offers additional suggestions and detail, and it will be helpful for trainers to read it before using the curriculum.

## **Self-Awareness**

As a trainer, it is important that you understand your personal values, your biases, and your own “hot spots” related to potentially traumatic material. This kind of self-awareness is invaluable in training and facilitating group discussion about sensitive material. To be an effective trainer, it is crucial that you

- identify how your own values, biases, and “hot spots” affect your behavior and communication;
- manage your own biases and emotional responses in the training environment;
- model respect and inclusion throughout the session; and
- identify, use and adapt your interpersonal skills to model trauma-informed practices for participants.

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<sup>1</sup> Retrieved from <http://www.multiplyingconnections.org/become-trauma-informed/walking-walk-trauma-informed-training>

## Training Tips

Consider the following items before delivering this training for the first time:

- 1) Know the difference between "listening" and "learning." Listening is passive, which means that lecture is the least efficient, least effective form of learning. Listening alone requires very little engagement on the learner's part. Therefore, don't talk more than 10-15 minutes without doing something interactive that stimulates discussion.
- 2) Emotions provide the information for building memories. Feelings are the tags that determine how important a particular experience is and whether the learner understands it as a memory worth saving. People remember what they feel far more than what they simply hear or see.
- 3) Acknowledge the power of feelings. Use the activities in the curriculum to elicit participants' emotions. Modulate your tone of voice to accentuate the experience. Allow participants to feel their way through an exercise. Do not tell them what they feel—ask them!
- 4) Vary your training methods to address the wide variety of learning styles. The curriculum incorporates several learning techniques; use all of them. Remember to keep lecture to a minimum and allow the process to work.
- 5) Use stories to engage people in learning. People don't always remember statistics, but stories are powerful because they engage the participants' emotions. Stories speak directly to the heart and the imagination, so people tend to pay more attention to them. You can connect with the group by strategically sharing personal experiences, personal stories available on video, or stories you have heard from others that relate to the topic you are discussing. When you share something that others can relate to, you help develop a rapport with the group and engage their emotions, which support the formation of new memories.
- 6) It is more important to ask good questions than to supply all the answers. Trainers often fail to ask enough questions. Instead, they present solutions, which can leave participants feeling frustrated and interfere with learning. After you ask questions, restate what you have learned from the responses and to ensure that you understood correctly. You can do this by simply restating two or three of the key points you heard from participants.
- 7) Keep your training skills and your knowledge of the subject matter sharp and up to date. Good presenters keep abreast of the newest training techniques and tools. You should improve upon your skills through reading on the topic, attending seminars, and seeking coaching from other facilitators. It is equally important that you keep your knowledge of trauma-related topics up to date, as well.

- 8) Establish your credibility in a low-key way. Participants do not care about your degrees, how smart you are, or what you have accomplished. While it's important to establish a baseline level of credibility, it is far more important that you care about how smart they are, what they know, and what they have done. At the beginning of the session, establish your credibility in an understated way (e.g., "We've done this training for 10 other peer-run programs across the country"). As a trainer, you nearly always come with a certain amount of credibility, even if the participants have never heard of you. It may be helpful to provide a brief statement—a couple of sentences—about the work and history of your organization to support understanding the passion behind why you do what you do.
- 9) Have a quick start and a big finish. Give participants the opportunity to do something active and interesting very early. Do not bog them down with a long introduction. The more quickly they engage, the better. Don't let the class fizzle out at the end. Try to end on a high note. Ask yourself, "What were the participants feeling when they left?"
- 10) Don't assume that just because you said it, they got it. Good trainers know how to slip in repetition in a stealthy way, with the material presented again, but from a different angle.
- 11) Be passionate and participants will respond in kind. Be honest, be authentic, and, especially, be passionate about your message. Your passion will keep them awake. Your passion will be infectious, and it will provide the emotional hook to help people remember the content.
- 12) Don't think of yourself as the expert. It's not about what you do or about what you know; it's about how participants feel about what they can do because of the learning experience you created. Rather than think of yourself as the expert, try thinking of yourself as "a person who creates learning experiences ... a person who helps others learn."

### **A Note About Language**

In keeping with the values and principles of trauma-informed approaches, this curriculum avoids using clinical language to the extent possible. Recognizing that trauma responses are natural human responses to extreme circumstances, not "illnesses," the curriculum does not focus on diagnostic terms such as post-traumatic stress disorder (PTSD). The curriculum does not use terms like "vicarious trauma" or "secondary trauma," because there is not a hierarchy of traumatic experiences. The focus is on using everyday language to talk about people's experiences, both staff and RSAT participants.

The curriculum does not talk about "triggering" or "triggers." These words can be experienced as violent and they don't really describe what happens when people are emphatically reminded of traumatic events by certain words, sounds, smells, attitudes, behaviors, or other's experiences. Instead, we refer to "hot button issues," "things that push your buttons," "things that bring up big emotions," "trauma reminders," or similar non-clinical phrases. It improves communication with RSAT participants and among staff in different roles if we use every-day, non-clinical language.

## Instructor Guidance

*As noted earlier, this curriculum is designed to be delivered as three separate 1.5-2 hour modules that can be presented on different days. However, it is flexible and may be presented in a variety of ways.*

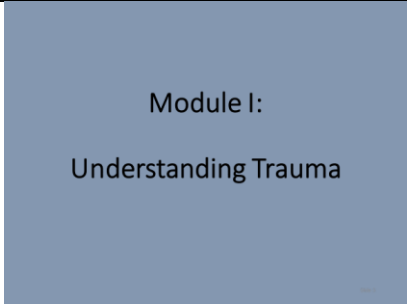
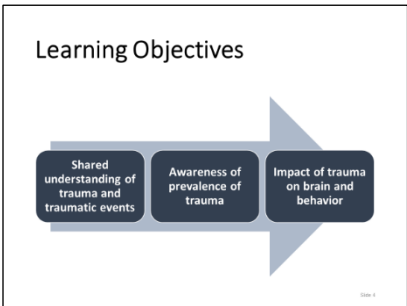
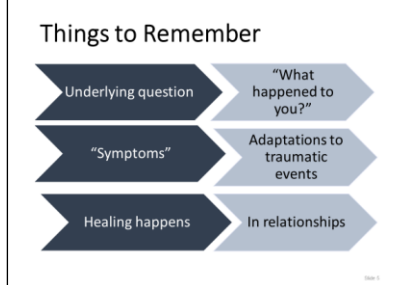
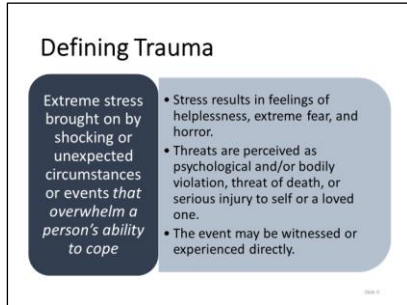
*For example, it might be presented as one day of training: 9:00 a.m. to 3:00 p.m., with a 1-hour lunch break and 10- to 15-minute breaks in the morning and in the afternoon. Or, the curriculum could be adapted and modified for shorter time periods by covering each topic as an overview and omitting some details, or by using only selected sections of the curriculum.*

The following pages provide guidance on slide presentation. Suggested text is indicated by italicized text preceded by ►.

### Introduction

Slide	Instructor Guidance
<p data-bbox="267 842 545 968">Introduction to Trauma and Trauma-Informed Approaches for RSAT Staff</p>	<p data-bbox="630 758 1414 831"><b>Slide 1:</b> Introduce yourself briefly and conduct a brief poll to gauge who is in the room. Possible questions include:</p> <ul data-bbox="680 852 1390 1003" style="list-style-type: none"> <li>• job titles</li> <li>• length of time in the agency</li> <li>• familiarity with the concept of trauma and trauma-informed approaches</li> </ul> <p data-bbox="630 1031 1414 1136">Tell participants where the restrooms are and review the schedule (preferably provided as a handout). If this is an all-day training, review when breaks and lunch will occur.</p> <p data-bbox="630 1163 1390 1268">Discuss the importance of self-care during the training and make participants aware that it's fine to step away for a break whenever needed.</p> <p data-bbox="630 1295 1382 1442">► <i>At times, the material presented is difficult to hear. It might bring up memories of painful times in our past. Please feel free to take a break at any time and speak to instructors or colleagues when you need support.</i></p>
<p data-bbox="237 1493 456 1518">Goals of the Training</p> <div data-bbox="237 1535 578 1591"> <p data-bbox="237 1535 578 1591">Module 1: To increase knowledge about trauma, its impact, and its prevalence among people with substance abuse issues and justice system involvement</p> </div> <div data-bbox="237 1608 578 1665"> <p data-bbox="237 1608 578 1665">Module 2: To increase knowledge about trauma-informed approaches and their benefits</p> </div> <div data-bbox="237 1682 578 1738"> <p data-bbox="237 1682 578 1738">Module 3: To provide information on implementing trauma-informed approaches in correctional settings</p> </div>	<p data-bbox="630 1465 1390 1539"><b>Slide 2:</b> Review the goals for each module and answer any questions.</p>

## Module I: Understanding Trauma

Slide	Instructor Guidance
 <p>Module I: Understanding Trauma</p>	<p><b>Slide 3:</b> Introduce Module 1, which provides an overview of trauma.</p>
 <p>Learning Objectives</p> <p>Shared understanding of trauma and traumatic events → Awareness of prevalence of trauma → Impact of trauma on brain and behavior</p>	<p><b>Slide 4:</b> Review the objectives for Module I.</p> <p>► <i>After completing this module, you will:</i></p> <ul style="list-style-type: none"> <li>• <i>Share an understanding of trauma and traumatic events</i></li> <li>• <i>Understand how prevalent trauma histories are among the people served by RSAT programs</i></li> <li>• <i>Understand the impact of trauma on the brain and behavior</i></li> </ul>
 <p>Things to Remember</p> <p>Underlying question → “What happened to you?”</p> <p>“Symptoms” → Adaptations to traumatic events</p> <p>Healing happens → In relationships</p>	<p><b>Slide 5:</b> Share the three important concepts to remember from this training.</p> <p>► <i>The underlying question is not “What’s wrong with you?” but “What happened to you?”</i></p> <p><i>What many call “symptoms” are actually adaptations to traumatic events.</i></p> <p><i>Healing happens in relationships, both with staff and with peers.</i></p>
 <p>Defining Trauma</p> <p>Extreme stress brought on by shocking or unexpected circumstances or events that overwhelm a person’s ability to cope</p> <ul style="list-style-type: none"> <li>• Stress results in feelings of helplessness, extreme fear, and horror.</li> <li>• Threats are perceived as psychological and/or bodily violation, threat of death, or serious injury to self or a loved one.</li> <li>• The event may be witnessed or experienced directly.</li> </ul>	<p><b>Slide 6:</b> Define trauma. Consider sharing a personal experience with trauma.</p> <p>► <i>There are many definitions of trauma. Essentially, it is a response to shocking circumstances and events that overwhelm a person’s capacity to cope.</i></p> <p><i>Trauma responses are individualized because each of us has different coping resources (and the same person may have fewer/more resources at different times depending on circumstances).</i></p> <p><i>Any given threatening event may traumatize one person but not another, since trauma occurs when an individual feels overwhelmed by the threat.</i></p>



### Defining Trauma (cont'd.)

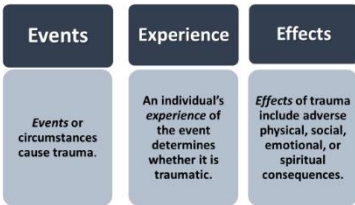
Individual trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or life threatening and has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

(Substance Abuse and Mental Health Services Administration [SAMHSA], 2014)

**Slide 7:** Explain the context for this definition of trauma.

- ▶ *A working group of researchers, practitioners, trauma survivors, and family members convened by the Substance Abuse and Mental Health Services Administration (SAMHSA) created this framework for understanding the complex nature of trauma.*

### The Three Es in Trauma



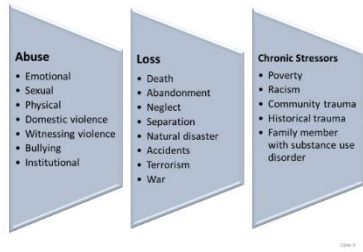
**Slide 8:** Describe the three “Es” of trauma.

- ▶ *The focus on **events** places the cause of trauma in the environment, not in some defect of the individual. This is what underlies the basic credo of trauma-informed approaches: “It’s not what’s wrong with you, but what happened to you.”*

*The focus on **experience** highlights the fact that not everyone will experience the same events as traumatic.*

*The identification of a broad range of potential **effects** reminds us that our response must be holistic—it’s not enough to focus on symptoms or behaviors. Our goal is to support a child to learn and grow or an adult to live a satisfying life.*

### Potentially Traumatic Events



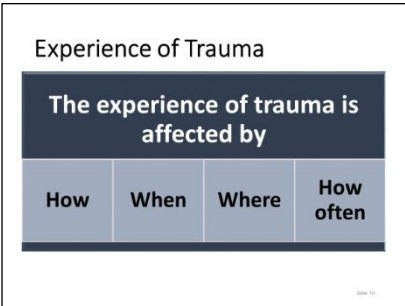
**Slide 9:** Review the wide range of potentially traumatic events, noting that the lists on the slide are not exhaustive.

- ▶ *Trauma can be caused by events that an individual doesn’t remember, such as events that occurred in early childhood.*

*It can be caused by events that are well-intentioned and necessary, such as medical procedures.*

*Trauma can be caused by an event that didn’t happen to the person but to a group that he or she identifies closely with—as in slavery or the Holocaust or the genocide of the Native American people.*

*Over time, chronic stressors can accumulate to cause trauma.*



**Slide 10:** Describe how an individual’s experience of trauma may be profoundly affected by how, when, where, and how often it occurs.

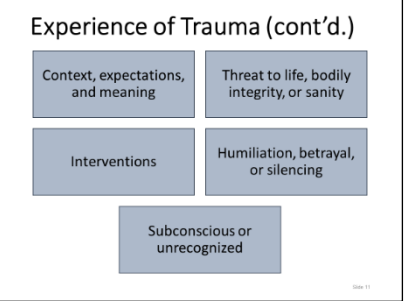
- ▶ *Trauma can result from a single devastating event, called single-episode (or acute) trauma, or it can result from multiple traumatic events over time.*

*Many individuals with justice system involvement have complex trauma, which comes from experiencing multiple sources of trauma over a lifetime.*

*Trauma can be totally unintentional, as when harm occurs through organizational procedures. For example, the routine practice of undressing for a medical exam can re-traumatize a person.*

*Systems can also unintentionally replicate the dynamics of an earlier trauma, causing re-traumatization.*

*Trauma can even occur from hearing about, watching, or interacting with others who have had traumatic experiences.*



**Slide 11:** Continue describing the experience of trauma.

- ▶ *The context, expectations, and meaning assigned to an event or circumstance may determine how it is experienced.*


*Trauma often includes a threat to life, bodily integrity or sanity, and/or the feeling of being overwhelmed and unable to cope.*

*Even interventions that are necessary or life-saving may be experienced as traumatic (e.g., medical interventions or removal from an abusive home).*

*Humiliation, betrayal, or silencing may compound the traumatic experience.*

*An individual may not be consciously aware that what they are experiencing (or have experienced in the past) is in fact a traumatic event, but it can still influence them.*

**Discussion Question**



How can the same event be traumatic for one person and not for another?

Slide 12

**Slide 12:** Facilitate discussion of the question presented on the slide.

**Effects of Trauma**

The effects of trauma on a person can be understood as normal responses to an abnormal situation.

Trauma has short- and long-term effects on:

Coping responses	Relationships	Physical and social development	Physical and emotional well-being
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Slide 13

**Slide 13:** Explain the third “e” of trauma: effects.

**Factors that Increase the Impact of Trauma**

Early occurrence	Blaming or shaming
Being silenced or not believed	Perpetrated by trusted caregiver

Slide 14

**Slide 14:** Describe factors that increase the impact of trauma.

► *The younger the age when trauma occurs, the more likely the consequences. We will discuss why this is true—even when the individual has no memory of the trauma—when we look at how trauma affects the brain, or the neurobiology of trauma.*

*Shame and humiliation are core features of the trauma experience for many people. These emotions can be devastating and impede healing. One of the most important messages you can give a trauma survivor is that no matter what happened, it wasn't their fault.*

*Sometimes trauma survivors are intimidated by their perpetrators into not telling what happened. Other times, trauma survivors who try to talk about what happened to them may be ignored or disbelieved. One of the most important things you can do for trauma survivors is to give them the chance to tell their stories. Healing starts when a person's personal experience is heard and validated.*

*The impact of trauma is magnified when the perpetrator is a trusted figure—an intimate partner, a relative, religious leader, coach, teacher, or therapist. This is often called “betrayal trauma” because the sense of betrayal can be profound.*

Adverse Childhood Experiences (ACE) Study

- Decade long: over 17,000 people involved
- CDC/Kaiser Permanente collaboration
- Largest epidemiological study of trauma ever done
- Looked at effects of adverse childhood experiences over the lifespan

Slide 15

**Slide 15:** Introduce the Adverse Childhood Experiences (ACE) Study.

► *The ACE Study is the largest health risk study on the relationship between trauma exposure and health issues. It was conducted by the Centers for Disease Control and Kaiser Permanente (a health insurer in San Diego).*

*Researchers surveyed more than 17,000 insured individuals from 1995-1997 about their history of adverse childhood experiences.*

*The ACE Study uses the ACE Score, which is a count of the total number of adverse childhood experiences reported by respondents, to assess the total amount of stress during childhood. Findings include:*

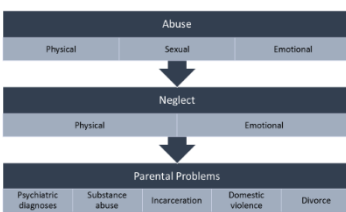
*Childhood abuse, neglect, and exposure to other traumatic stressors are common.*

*Almost two-thirds of study participants reported at least one adverse childhood experience, and more than 1 in 5 reported three or more adverse childhood experiences.*

*The short- and long-term outcomes of these childhood exposures include a multitude of health and social problems.*

*As the ACE score increases, the risk for certain health problems increases in a strong and graded fashion and, with that, a direct, negative impact on mortality and longevity.*

Three ACE Categories



Slide 16

**Slide 16:** Introduce the ACE categories.

► *Researchers carrying out the ACE study asked adults if they had experienced any of these 10 issues as children. A child might experience other types of negative events, but these were the ones chosen for this study.*

### ACE Study Findings: Summary

Adverse Childhood Experiences	Neurobiological Impacts and Health Risks	Long-term Health and Social Problems
The more types of adverse childhood experiences...	the greater the neurobiological impacts and health risks, and...	the more serious the lifelong consequences to health and well-being.

(Felitti et al., 1998)

**Slide 17:** Share the summary of ACE study findings presented on the slide.

### Trauma Prevalence in Children

<b>94%</b> of children in a study of juvenile justice settings experienced trauma. <sup>1</sup>	<b>92%</b> of youth in residential and 77% in non-residential mental health treatment reported multiple traumatic events. <sup>2</sup>	<b>71%</b> of children are exposed to violence each year. <sup>3</sup>
<b>3.5-10 million</b> children witness violence against their mother each year. <sup>4</sup>	<b>676,000</b> children are abused or neglected each year. <sup>5</sup>	<b>1 in 4 girls</b> <b>1 in 6 boys</b> are sexually abused before adulthood. <sup>6</sup>

<sup>1</sup> Rosenberg et al., 2014; <sup>2</sup> National Child Traumatic Stress Network, 2011; <sup>3</sup> Finkelhor, Turner, Shattuck, & Hamby, 2013; <sup>4</sup> Child Witness to Violence Project, n.d.; <sup>5</sup> Child Welfare Information Gateway, 2018; <sup>6</sup> Finkelhor, Browne, Lewis, & Smith, 1990

**Slide 18:** Share statistics on trauma prevalence in children.

► *A high percentage of children are exposed to potentially traumatizing events on a regular basis.*

*Exposure to traumatic events greatly increases the likelihood that children will eventually receive behavioral health and social services.*

*These statistics are so high that many social service settings assume that every child they see may have experienced some form of trauma at some time, whether anyone knows about it or not.*

### ACE and RSAT Participants

"A male child with an ACE score of 6 has a 4,600% increase in the likelihood of later becoming an IV drug user when compared to a male child with an ACE score of 0.

Might heroin be used for the relief of profound anguish dating back to childhood experiences? Might it be the best coping device that an individual can find?"

(Felitti, 2002)

**Slide 19:** Point out the applicability of the statistic presented on the slide to RSAT participants.

### Trauma in Adults: Substance Abuse

Up to 65% of all clients in substance abuse treatment report childhood abuse.  
(SAMHSA, 2013)

Up to 75% of women in substance abuse treatment report trauma histories.  
(SAMHSA, 2009)

Almost 1/3 of all veterans seeking treatment for a substance use disorder have PTSD.  
(National Center for PTSD)

**Slide 20:** Share statistics on trauma among adults who abuse substances.

► *A very high percentage of people who abuse substances have been exposed to potentially traumatizing events as children and/or as adults. Many substance abuse treatment settings assume that every person they see may have experienced some form of trauma in their life, whether anyone knows about it or not. Understanding the role of trauma is key to effective treatment.*

**Impact on Adult Health**

**Adverse childhood experiences have serious health consequences for adults.**

- **Adoption of health risk behaviors as coping mechanisms** (e.g., eating disorders, smoking, substance abuse, self-harm, risky sexual behavior)
- **Severe medical conditions** (e.g., heart disease, pulmonary disease, liver disease, sexually transmitted disease, cancers)
- **Early death**


(Felitti et al., 1998)

**Slide 21:** Discuss the impact that adverse childhood experiences can have on adult health.

- ▶ *Adopting health risk behaviors can be a coping response to trauma, such as drinking alcohol to manage flashbacks. This can put the person at greater risk by perpetuating the cycle of trauma and adversely affecting their physical health and mortality.*

*Research shows a connection between adverse childhood experiences, or potentially traumatic experiences a person had before age 18, and health risk later in life.*

**Discussion Question**



What makes an event or circumstance traumatic?

**Slide 22:** Facilitate discussion of the question presented on the slide.

**Trauma Responses**


Behavioral	Emotional/ Physical	Psychological
Blowing up when corrected	Difficulty trusting others	Confusing safety and danger
Resisting change	Feeling very sad, angry, afraid, or numb	Trouble concentrating
Protective of personal space	Unexplained medical problems	Difficulty imagining the future
Reckless, self-destructive behavior	Flashbacks or frequent nightmares	Not remembering times of one's life
Irritability	Sensitivity to noise or touch	Always expecting something bad to happen

**Slide 23:** Discuss various responses to trauma.

- ▶ *None of these signs is always associated with trauma. However, each of them can be adaptations to the neurobiological changes associated with trauma. Even one of these signs should be enough to raise the possibility of trauma.*

*What we call “symptoms” may continue into adulthood and may even play an important protective or survival role in a person’s life. Knowing that “symptoms” may be adaptations to underlying trauma can change the way we view people.*

**Biological Reactions to Fear**



**Slide 24:** Explain the brain’s physical response to fear.

- ▶ *The “fire alarm” of the brain is in the amygdala. It sounds the alarm about a threat, activating the fear response. The frontal lobes of the cortex—at the top or the thinking part of the brain— shut down to make sure the person is focusing completely on survival, which is why it’s so hard to think when you are in a crisis.*

*At the same time, the ability to perceive new stimuli decreases, and the area of the brain responsible for speech (“Broca’s area”) shuts down. When, people talk about*

*“speechless terror” or “being scared speechless,” they are not being metaphorical. They are describing a real response of the brain. People in distress may not be able to respond to a question from someone who asks how to help.*

*When a person remembers a traumatic event, often the fear response is activated, just like it was when the event occurred. From the brain’s perspective, the threat is actually happening again.*

**“Problem” or Adaptation?**

Problem Behavior		Adaptation to Trauma
Non-compliant or combative	FIGHT	Struggling to regain or hold onto personal power
Treatment resistant or uncooperative	FLIGHT	Disengaging or withdrawing
Passive or unmotivated	FREEZE	Giving in to those in power

**Slide 25:** Explain how a trauma-informed approach recognizes “problem” behaviors as adaptations to trauma.

► *Danger activates fight, flight or freeze responses. Some common behaviors of trauma survivors—behaviors that are often labeled as “problems” by the criminal justice system and other systems—can be directly linked to these responses and to the effects that trauma has on the brain.*

*This slide presents three sets of “problems” that are often attributed to incarcerated people in treatment and shows how the behavior may be a survival mechanism tied to a flight, flight or freeze response.*

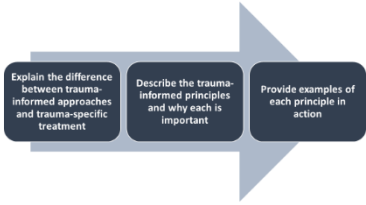
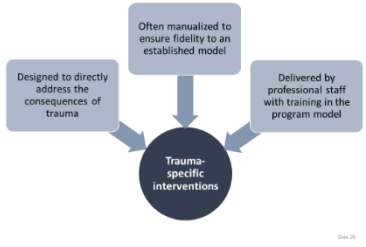
*First is the fight response. Someone who struggles too hard to hold onto personal power may be labeled as non-compliant or combative.*

*Second is the flight response. Someone who emotionally withdraws or disengages too much may be labeled as treatment resistant or uncooperative.*

*Third is the freeze response. Someone who gives in too easily to authority may be labeled as passive or unmotivated.*

*Many of the people we serve have survived circumstances that we can hardly imagine. What we often label as pathological may be the very things that helped them to survive.*

## Module 2: Understanding Trauma-Informed Approaches

<p style="text-align: center;">Module 2</p> <p style="text-align: center;">Understanding Trauma-Informed Approaches</p>	<p><b>Slide 26:</b> Introduce Module 2, which discusses trauma-informed approaches.</p>
<p>Learning Objectives</p> 	<p><b>Slide 27:</b> Review the objectives for Module 2.</p> <p>► <i>After completing this module, you will be able to:</i></p> <ul style="list-style-type: none"> <li>• <i>Explain the difference between trauma-informed approaches and trauma-specific treatment</i></li> <li>• <i>Describe the trauma-informed principles and why each is important</i></li> <li>• <i>Provide examples of each principle in action</i></li> </ul>
<p>Trauma-Specific Treatment</p> 	<p><b>Slide 28:</b> Discuss trauma-specific treatment.</p> <p><i>Trauma-informed approaches are different from trauma-specific treatment interventions. but both are important. Trauma-informed approaches create an atmosphere that recognizes the impact of trauma on survivors and minimizes retraumatization. It's not necessary to know if specific individuals are trauma survivors; rather, the focus is on creating an environment that assumes anyone there may be a trauma survivor. Trauma-specific treatments include specific types of one-on-one therapies offered by licensed clinicians with training in the specify treatment modality. This includes Eye Movement Desensitization and Reprocessing (EMDR), Prolonged Exposure Therapy, Trauma Resolution Therapy, and Trauma-Focused Cognitive Behavioral Therapy.</i></p> <p><i>In additional, there are proprietary manualized group or individual treatment programs available for purchase; these include <b>Seeking Safety: A Treatment Manual for PTSD and Substance Abuse</b>, by Lisa Najavits, and <b>Risking Connection</b>, from the Sidran Foundation.</i></p>



Overview of the Principles

- Six principles that guide a trauma-informed change process
- Developed by national experts, including trauma survivors
- Goal: Establish common language/framework
- Values-based, not a rigid formula

(SAMHSA, 2014)

**Slide 29:** Provide an overview of SAMHSA’s trauma-informed principles.

► *SAMHSA’s trauma-informed principles emerged from a year-long process involving trauma survivors, family members, practitioners, researchers, and policymakers. During a public comment period, thousands of individuals wrote in with feedback on the definitions and overall approach.*

*The goal was to develop a common language and framework. As more agencies and organizations work to become trauma-informed—and as more and more claim to be trauma-informed—there needs to be a standard way to define and assess consistency with the approach.*

*The principles are values-based. Unlike “manualized” models for trauma-specific treatment interventions, these principles can be applied in a wide variety of settings, in many ways, using whatever resources are available.*

*Implementing a trauma-informed approach requires constant attention and caring; it’s not about checking off a list.*

*Think about something as basic as respect or compassion. Can you do it once, implement a policy, and then check it off as done? Trauma-informed approaches are about a way of being, not a specific set of actions or implementation steps.*

Key Principles

Safety	Trustworthiness and Transparency	Peer Support
Collaboration and Mutuality	Empowerment, Voice, and Choice	Cultural, Historical, and Gender Issues

**Slide 30:** Present the six trauma-informed principles.

► *The national workgroup convened by SAMHSA agreed upon six key principles of a trauma-informed approach. We will examine each principle in detail.*

## Principle 1: Safety

Throughout the organization, staff and the people they serve feel physically and psychologically safe.

### Slide 31: Introduce Principle 1: Safety

- ▶ *Principle 1 is about safety. This means both physical and psychological safety for participants **and** staff. The physical setting must be safe, and interpersonal interactions must promote a sense of safety.*

### Who Defines Safety?



Blanch & Prescott, 2002.

### Slide 32: Discuss the nuances of safety.


- ▶ *Many of these principles—like safety—sound so simple and obvious that you might wonder why they need to be highlighted. But, if we go below the surface, a more complicated reality emerges.*

*Laura Prescott, a trauma survivor and researcher, asked both patients and staff of psychiatric hospitals, and inmates and staff in jails and prisons, what made them feel safe. She found that point for point, staff and inmates/patients defined safety in almost completely opposite terms. It turned out that the very things that staff were doing to make the units safer were making inmates and patients feel less safe. For example:*

- *inmates and patients felt safest when they had maximum choice, while staff felt safest with routine and predictability.*
- *Staff felt safe with using force (restraint, isolation, etc.) to de-escalate situations, while inmates and patients felt safest when free from coercion, threats, punishment & harm.*
- *Patients and inmates felt safe when they could own and express their feelings without fear of reprisal, while staff felt safe when expression of strong emotions was suppressed.*

*So, what can you do in a situation like this? First, recognizing that safety may look different depending on your role and situation—or your personal history—is an important first step. The best thing you can do is to ask everyone what makes them feel safe and unsafe.*

*Ensuring a sense of safety may mean rethinking policies and practices to attend to what both trauma survivors and*

	<p><i>staff mean by safety, within the limits of what is possible in correctional settings.</i></p>
<p>Discussion</p> <p>Do staff feel safe? Why or why not?</p> <p>Do participants feel safe? How do you know?</p> <p>What changes could be made to address security concerns?</p>	<p><b>Slide 33:</b> Facilitate summary discussion on Principle 1.</p> <p>► <i>Given the realities of rules and regulations in correctional settings, how can these issues best be addressed?</i></p>
<p><b>Principle 2: Trustworthiness and Transparency</b></p> <p>Organizational operations and decisions are conducted with transparency and with the goal of building and maintaining trust among clients, family members, staff, and others involved with the organization.</p>	<p><b>Slide 34:</b> Introduce Principle 2: Trustworthiness and Transparency.</p>
<p><b>Building Trustworthiness</b></p>  <p>Making sure people understand their options and lack of options</p> <p>Being authentic</p> <p>Directly addressing limits to confidentiality</p>	<p><b>Slide 35:</b> Describe ways to build trustworthiness.</p> <p>► <i>One of the most powerful ways of building trust is to give people full and accurate information. Telling people what's going on and what's likely to happen next can be very important. Being clear is essential. Telling people they have more control than they really do will eventually destroy trust. It's important to be direct about what policies can be amended and what rules are non-negotiable.</i></p> <p><i>Sharing your own reactions and responses in a truthful manner—being authentic—is also essential. Trauma survivors often have finely tuned “radar” to detect other people’s emotional states. They have had to develop this capacity, a form of vigilance, to protect themselves. If you are untruthful about your feelings—even if you are trying to protect the other person—they are likely to detect it, and trust goes out the window.</i></p> <p><i>Similarly, if you are required to break confidentiality when someone talks about wanting to hurt themselves, it's better to tell the individual up front than to assure them of confidentiality and then break that trust.</i></p>

## Discussion

How can we promote trust?

Do RSAT participants trust staff? How do you know?

What changes could be made to address trust issues in correctional settings?

Slide 36

**Slide 36:** Facilitate summary discussion on Principle 2.

*Given the realities of rules and regulations in correctional settings, how can these issues best be addressed?*

## Principle 3: Peer Recovery Support



SAMHSA, 2017

Slide 37

**Slide 37:** Introduce Principle 3: Peer Recovery Support.

*Read the list of benefits of peer recovery supports.*

## Definition and Principles of Peer Support

**Peer support: A flexible approach to building mutual, healing relationships among equals, based on core values and principles**



Slide 38

**Slide 38:** Share the definition and principles of peer support, supplementing the information on the slide with the points below.

► *Peer support relies on the promotes development of authentic mutual relationships; it doesn't apply a cookie-cutter approach to everyone. The heart of peer support involves building trust, which isn't possible if people feel that peer support staff are acting as proxies for staff or are reporting on people's behavior.*

*Peer support doesn't offer top-down "helping" that disempowers people by taking away choice and voice. It is not "peer counseling," which implies that one person knows more than the other. Peer support is about power-sharing.*

*Peer support doesn't use clinical language or focus on what's "wrong" with people.*

*Trauma-informed peer support is important for not only people who receive services. It is important that staff who are trauma survivors have access to peer support, too.*

## Discussion

Does your program offer access to peer support for participants? If so, how?

Does your organization offer peer support for staff?

What barriers are there to implementing peer support in your work setting?

Slide 39

**Slide 39:** Facilitate summary discussion on Principle 3.

► *Given the realities of rules and regulations in correctional settings, how can these issues best be addressed?*

## Principle 4: Collaboration and Mutuality

- Partnering occurs between staff and participants.
- There is a leveling of power differences among staff, from direct care to administrators
- Healing happens in relationships and in the meaningful sharing of power and decision-making.

Slide 40

**Slide 40:** Introduce Principle 4: Collaboration and Mutuality

We recognize that there are many challenges to implementing the principle of collaboration in correctional settings, which are hierarchical by design.

But, with strong leadership and a commitment at the top to change, it is possible to create a culture change within correctional settings.

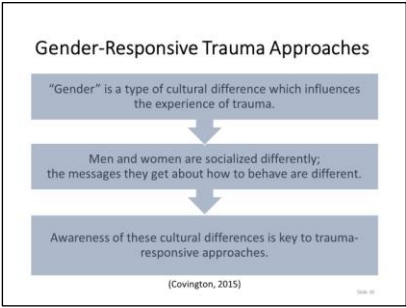
Bridgewater State Hospital, a Massachusetts facility housing men found not guilty by reason of insanity and those deemed unable to participate in their defense because of mental health issues, is under the auspices of the Department of Corrections. For many years, it relied on excessive restraint and seclusion to punish and control inmates. There were several inmate deaths under suspicious circumstances and evidence of cover-ups.

In 2017, Gov. Charlie Baker made culture change at Bridgewater a priority. He replaced the administration and staff with a private firm which introduced more humane practices that enabled the facility to reduce restraint by 98% and seclusion by 99% in 5 months. The changes included bringing in a nationally known expert on trauma-informed approaches, Kevin Ann Huckshorn, as deputy administrator. Physical changes in the environment included remodeling dormitories into private rooms, painting and decorating the facility, and adding group activities such as gardening and music. Inmates are now called “persons served,” and staff rely on collaboration and mutual respect to build relationships with those served.

To ensure this kind of change, staff must examine their own behavior and attitudes toward power and collaboration. It’s important to learn to distinguish when exercising power is absolutely necessary, and when adopting a more collaborative approach may improve the sense of safety of

	both staff and residents.
<p><b>Examples of Collaboration</b></p> <p>Self-directed support groups where professionals facilitate, but do not direct the discussion.</p> <p>Both staff and residents in a correctional facility are involved in every task force and committee and each group is recognized for its valuable input.</p>	<p><b>Slide 41:</b> Preface this slide by explaining that this principle encompasses both collaboration between staff and participants <i>and</i> among different types and levels of staff.</p>
<p><b>Discussion</b></p> <p>Can you think of examples of true partnership between staff and participants?</p> <p>What about partnership between top-level administrators and staff?</p> <p>What changes might decrease the power differentials in your work setting?</p>	<p><b>Slide 42:</b> Facilitate summary discussion on Principle 4.</p> <p>► <i>Given the realities of rules and regulations in correctional settings, how can these issues best be addressed?</i></p>
<p><b>Principle 5: Empowerment, Voice, and Choice</b></p> <ul style="list-style-type: none"> <li>• Individuals' strengths and experiences are recognized and built upon.</li> <li>• Having a voice and choice is validated.</li> <li>• The organization fosters a belief in resilience.</li> <li>• Participants are supported in developing self-advocacy skills and self-empowerment.</li> </ul>	<p><b>Slide 43:</b> Introduce Principle 5.</p>
<p><b>Examples</b></p> <ul style="list-style-type: none"> <li>Asking at RSAT intake: "What strengths do you bring to the community?"</li> <li>Offering support services designed and led by participants</li> <li>Turning "problems" into strengths</li> </ul>	<p><b>Slide 44:</b> Point out that this principle reflects a positive, creative attitude, rather than a specific technique.</p> <p>► <i>Empowerment, voice, and choice apply to staff as well as the people who are incarcerated. It's important to tap the strengths of everyone in the facility, which may lead to innovative collaboration. For example, someone who is prone to self-injurious behavior could be asked to identify all the possible ways to inflict self-injury and inform staff. That person is more likely to notice dangerous items in the environment than others are.</i></p>

<p><b>Discussion</b></p> <p>How can you best use participants' strengths?</p> <p>How can you help create empowerment, voice, and choice for participants? for staff?</p> <p>What policies or practices do the opposite: take voice, choice, and decision-making away? Can any of these things be changed?</p> <p style="text-align: right;"><small>Slide 45</small></p>	<p><b>Slide 45:</b> Facilitate summary discussion on Principle 5.</p> <p>▶ <i>Given the realities of rules and regulations in correctional settings, how can these issues best be addressed?</i></p>
<p><b>Principle 6: Cultural, Historical, and Gender Issues</b></p> <p>The organization moves past cultural stereotypes and biases, offers gender-responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.</p> <p style="text-align: right;"><small>Slide 46</small></p>	<p><b>Slide 46:</b> Introduce Principle 6: Cultural, Historical, and Gender Issues</p>
<p><b>Trauma and Incarceration</b></p> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid gray; padding: 5px; width: 45%;"> <p>Prevalence of lifetime traumatic events among current/formerly incarcerated men is 62-98%.</p> <p><small>(Pettus-Davis, Renn, Lacasse, &amp; Motley, 2018)</small></p> </div> <div style="border: 1px solid gray; padding: 5px; width: 45%;"> <p>"77 to 90% of women with drug dependency in prison report extensive histories of emotional, physical, and sexual abuse."</p> <p><small>(Wallace, Conner, &amp; Dass-Brailsford, 2011)</small></p> </div> </div> <p style="text-align: right;"><small>Slide 47</small></p>	<p><b>Slide 47:</b> Present statistics on the prevalence of trauma among men and women who are or have been incarcerated.</p> <p>▶ <i>Men who have not been incarcerated have lifetime trauma rates between 22 and 47 percent. This is much lower than what Pettus-Davis and colleagues discovered in their review of studies of trauma histories among men who were currently/formerly incarcerated: 62-98 percent.</i></p> <p><i>Prevalence varied based on how questions were phrased, the demographics of the men surveyed, and other factors. The authors believe that traumatic histories are often under-reported by incarcerated men out of shame or the desire to present a strong masculine image.</i></p> <p><i>Nearly all incarcerated women are trauma survivors.</i></p>
<p><b>Gender Differences</b></p> <div style="display: flex;"> <div style="border: 1px solid gray; padding: 5px; width: 30%;"> <p>Incarcerated men and women have similar rates of trauma, but the types of trauma they experience differs.</p> <p style="text-align: right;"><small>(Pettus-Davis, Renn, Lacasse, &amp; Motley, 2018)</small></p> </div> <div style="border: 1px solid gray; padding: 5px; width: 65%;"> <ul style="list-style-type: none"> <li>• Men more often witnessed violence as children.</li> <li>• Men were more likely victims of non-sexual violence in adolescence.</li> <li>• Men are more likely to experience traumatic events <b>during</b> incarceration.</li> <li>• Incarcerated women report higher levels than men of sexual abuse and assault in childhood, adolescence, and adulthood.</li> </ul> <p style="text-align: right;"><small>Slide 48</small></p> </div> </div>	<p><b>Slide 48:</b> Present research findings on the differences in trauma experiences between genders.</p>

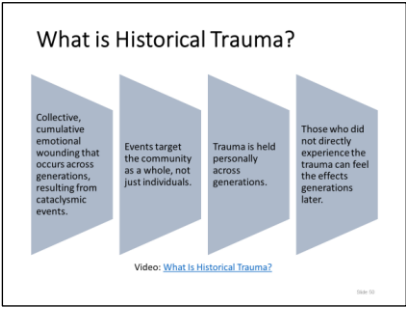


**Slide 49:** Share highlights of Stephanie Covington’s work.

► *In our society, the culture of men and the culture of women are quite different. In our male-dominated culture, efforts to be gender-neutral often end up being male-focused.*

*. It’s important that staff facilitating trauma groups in correctional settings be of the same gender as participants. People feel safer disclosing with others of their gender.*

*It is also important to be aware of and responsive to the cultural differences of non-binary and transgender individuals.*



**Slide 50:** Describe historical trauma.

► *Horrific experiences, such as genocide, slavery, forced relocation, and destruction of cultural practices, can cause cumulative emotional wounds carried across generations.*

*This may result in these communities experiencing higher rates of emotional distress, physical illness, substance abuse, and erosion of families and community structures.*

*The persistent cycle of trauma destroys family and communities and threatens the vibrancy of entire cultures.*

*Historical trauma is not just about what happened in the past. It's about what's still happening.*

*This 6-minute video from the University of Minnesota Extension features scholars and practitioners defining and discussing the origins and manifestations of historical trauma.*

<https://www.youtube.com/watch?v=AWmK314NVrs>

### Leveraging Cultural Traditions for Healing

The Women's Community Correctional Center of Hawaii built a trauma-informed culture based on the Hawaiian concept of *pu'uhonua*, a place of refuge, asylum, peace, and safety.

Creating a Place of Healing and Rejuvenation


Brief available at [https://www.ncmtpd.org/sites/default/files/7014\\_hawaii\\_trauma\\_brief\\_201311.pdf](https://www.ncmtpd.org/sites/default/files/7014_hawaii_trauma_brief_201311.pdf)

**Slide 51:** Share the case example of a culturally sensitive response to meeting the needs of incarcerated women who have experienced trauma.

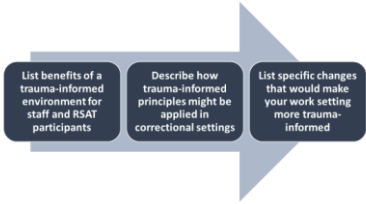
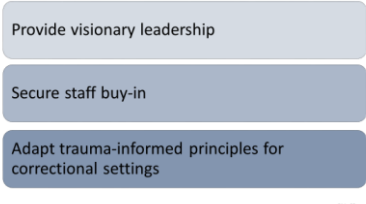
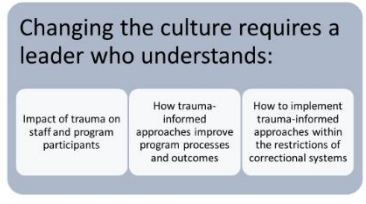
► *Recognizing that virtually all of its inmates are trauma survivors, the Women’s Community Correctional Center (WCCC) in Hawaii reinvented itself as a place of healing for the women it serves. They adopted a community-building approach to culture change at the facility within a trauma-informed framework.*

*Warden Mark Patterson, a Native Hawaiian, was inspired by the Hawaiian concept of the *pu`uhonua*, a place of*



	<p><i>refuge, asylum, peace, and safety. Under the ancient system of laws known as kapu, in which law-breaking was punishable by death, someone who broke a law and was able to make his or her way to a pu`uhonua would receive sanctuary. There, a priest performed a ritual that absolved the person of blame, which allowed the law-breaker to return to their village and resume their life.</i></p> <p><i>The spirit of pu`uhonua—the opportunity to heal and live a forgiven life—informs the vision that is changing the environment for both incarcerated women and staff at WCCC.</i></p>
<p>Discussion Question</p>  <p>What cultural and gender-related issues do RSAT participants express?</p>	<p><b>Slide 52:</b> Facilitate discussion of the question presented on the slide.</p>

## Module 3: Implementing Trauma-Informed Approaches in Correctional Settings

<p style="text-align: center;">Section III</p> <p style="text-align: center;">Implementing Trauma-Informed Approaches in Correctional Settings</p>	<p><b>Slide 53:</b> Introduce Module 3, which focuses on implementing trauma-informed approaches in correctional settings.</p>
<p style="text-align: center;">Learning Objectives</p> 	<p><b>Slide 54:</b> Review the objectives for Module 3.</p> <p>► <i>After completing this module, you will be able to:</i></p> <ul style="list-style-type: none"> <li>• <i>List benefits of a trauma-informed environment for staff and RSAT participants</i></li> <li>• <i>Describe how trauma-informed principles might be applied in correctional settings</i></li> <li>• <i>List specific changes that would make your work setting more trauma-informed</i></li> </ul>
<p style="text-align: center;">How Can Correctional Settings Become Trauma-Informed?</p> 	<p><b>Slide 55:</b> Initiate session with a high-level view of how correctional settings can become trauma-informed. This slide serves as an advance organizer for the rest of the slide.</p>
<p style="text-align: center;">Provide Visionary Leadership</p> 	<p><b>Slide 56:</b> Briefly discuss what is expected of a leader seeking to implement trauma-informed principles.</p>

**Secure Staff Buy-In**

How does a trauma-informed environment help staff?

- Job duties become easier.
- Facilities are safer.
- Programming is more productive and effective.

(Kubiak, Covington & Hillier, 2017)

**Slide 57:** Discuss how creating a trauma-informed environment is a “win-win” for staff.

► *Trauma-informed approaches that showed how to put the 6 principles described in Module 2 into practice can help create a calmer, less threatening atmosphere where people can feel more comfortable exploring how past traumas influence their feelings and behavior.*

*This reduces stress and lowers tensions for both staff and RSAT participants, making it easier for all to communicate clearly and respectfully.*

*Programming is more productive and effective under such conditions.*

Adapting Trauma-Informed Principles for Correctional Settings

Safety	Trustworthiness and Transparency	Peer Support
Collaboration and Mutuality	Empowerment, Voice, and Choice	Cultural, Historical, and Gender Issues

**Slide 58:** Preview the next section of the training.

► *Next, we will discuss how each of the principles of trauma-informed approaches that we learned about in Module 2 can be implemented in correctional settings.*

Conditions in correctional settings may be a source of trauma or may exacerbate existing trauma responses.

Loss of control over one's life	Movement monitored; privacy limited	Strip searches and pat-downs	Frequent threats of violence	Distrust between staff and inmates and among inmates
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(Kubiak, Covington & Hillier, 2017)

**Slide 59:** Review the examples of conditions in correctional settings that can be traumatic.

► *Security practices within correctional settings may force us to adapt or compromise some of these principles. Each of these conditions can make it hard to avoid re-traumatizing people, but let's think of creative ways that we can make this work for RSAT participants.*

► *For example, in one facility, staff apologize when they must perform a strip search and tell the individual exactly what they are going to do at each step before they do it. This was found to reduce anxiety and shame.*

Discuss: Safety in Your Work Setting

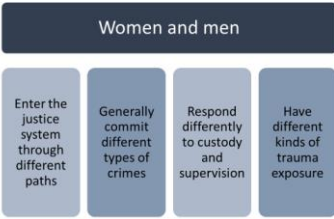
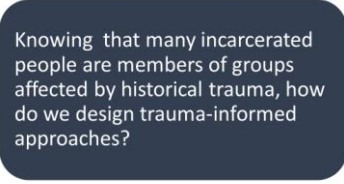
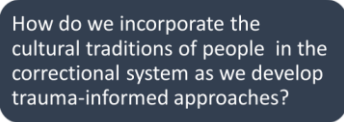

Do staff feel safe? Why or why not?

Do participants feel safe? How do you know?

What changes could be made to address safety concerns?

**Slide 60:** Explain that the rest of the training primarily provides an opportunity for participants to have deeper discussions about what it would take to implement trauma-informed approaches within the parameters of the rules and the organizational culture of their work setting. Facilitate discussion using the prompts on the corresponding slides, starting with safety in the work setting.

<p>Discuss: Trustworthiness &amp; Transparency</p> <p>How can you promote trust with participants? With other staff?</p> <p>Do RSAT participants trust staff? How do you know?</p> <p>What changes are possible to address trust issues in correctional settings?</p> <p style="text-align: right;"><small>Slide 61</small></p>	<p><b>Slide 61:</b> Facilitate discussion of questions on slide.</p>
<p>Discuss: Peer Recovery Support</p> <p>Does your program offer access to peer recovery support for participants?</p> <p>If so, what form does this take?</p> <p>What barriers exist to implementing peer recovery supports in your work setting?</p> <p style="text-align: right;"><small>Slide 62</small></p>	<p><b>Slide 62:</b> Facilitate discussion of questions on slide.</p>
<p>Discuss: Mutuality and Collaboration</p> <p>Can you think of examples of true partnership between staff and participants?</p> <p>What about partnerships between top-level administrators and staff?</p> <p>What changes might lessen the power differentials in your work setting?</p> <p style="text-align: right;"><small>Slide 63</small></p>	<p><b>Slide 63:</b> Facilitate discussion of questions on slide, supplementing with the following questions, as necessary:</p> <ul style="list-style-type: none"> <li>▶ <i>Given the realities of correctional settings, do you feel like partnerships are feasible?</i></li> <li>▶ <i>If so, how might they look different than partnerships between clients and staff in non-correctional settings?</i></li> <li>▶ <i>Can you imagine ways to lessen power differentials?</i></li> </ul>
<p>Discuss: Empowerment, Voice, and Choice</p> <p>How can you help create empowerment, voice and choice for participants? For staff?</p> <p>What policies and practices take away voice, choice, and decision-making? Can any of these things be changed?</p> <p style="text-align: right;"><small>Slide 64</small></p>	<p><b>Slide 64:</b> Facilitate discussion of questions on slide, supplementing with the following questions, as necessary:</p> <ul style="list-style-type: none"> <li>▶ <i>Given the obvious restrictions of correctional settings, what would empowerment look like?</i></li> <li>▶ <i>What kind of voice can people have within the limitations of the environment?</i></li> <li>▶ <i>Is the idea of “choice” viable in correctional settings? If so, how, and to what extent?</i></li> </ul>

<p>Discuss: Gender-Related Concerns</p>  <p>Slide 65</p>	<p><b>Slide 65:</b> Facilitate discussion of questions on slide, supplementing with the following questions, as necessary:</p> <ul style="list-style-type: none"> <li>▶ <i>What differences do you see between the environments of men’s prisons and women’s prisons?</i></li> <li>▶ <i>How might trauma-informed approaches be designed differently for men’s and women’s prisons because of these differences?</i></li> </ul>
<p>Discuss: Historical Trauma</p>  <p>Slide 66</p>	<p><b>Slide 66:</b> Facilitate discussion of questions on slide, supplementing with the following questions, as necessary:</p> <ul style="list-style-type: none"> <li>▶ <i>How important is it for RSAT participants to understand the idea of historical trauma?</i></li> <li>▶ <i>How do we communicate the idea of historical trauma without re-traumatizing individuals?</i></li> <li>▶ <i>How do we talk with RSAT participants about the specific historical traumas that their ethnic or cultural group has experienced, such as Native Americans’ removal from tribal lands or African-Americans’ history of slavery?</i></li> </ul>
<p>Discuss: Cultural Healing Traditions</p>  <p>Slide 67</p>	<p><b>Slide 67:</b> Facilitate discussion of questions on slide, supplementing with the following questions, as necessary:</p> <ul style="list-style-type: none"> <li>▶ <i>What do you need to know and what questions would you ask to get good information about healing traditions in different cultures?</i></li> <li>▶ <i>How can you incorporate these understandings into your RSAT work?</i></li> </ul>
<p>To Support Healing From Trauma</p>  <p>Slide 68</p>	<p><b>Slide 68:</b> Prepare to wrap up the training.</p> <ul style="list-style-type: none"> <li>▶ <i>Learning about how widespread trauma is and how it can affect all aspects of a person’s life can sometimes feel overwhelming. But people are resilient. With support, people can survive and thrive, even after devastating trauma. Even people with extremely high ACE scores can live long and healthy lives, especially if they have support. When providing this support to your clients, remember to be curious, empathetic, and flexible.</i></li> </ul>

Moving Forward

What one thing are you able and willing to do to create an environment where healing is possible for RSAT participants?

**Slide 69:** Ask each participant to name one action they can take to promote healing from trauma in their workplace. After everyone who wants to share has done so, thank participants for their willingness to learn about trauma-informed approaches.

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## Additional Resources

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