NAADAC

GENDER RESPONSIVE TRAUMA INFORMED CARE "THE FIRST 72 HOURS"

PRESENTED BY:

CHARLENE SEARS-TOLBERT

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>> SAMSON TEKLEMARIAM: So we're going to start. As we begin, I will do that first bumper slide for about 4 minutes of intro and then I'll hand it off to you and do the presentation and then I'll need 2 to 3 minute to wrap-up at the end.

>> CHARLENE SEARS-TOLBERT: Wonderful.

>> SAMSON TEKLEMARIAM: All right. We'll start now.

[The broadcast is now starting, all attendees are in "listen-only" mode.]

>> SAMSON TEKLEMARIAM: Hello, everyone, and welcome to today's webinar on Gender Responsive Trauma Informed Care "The First 72 Hours" presented by Charlene Sears-Tolbert. It's great you can join us today. My name is Samson Teklemariam and I'm the training Director of NAADAC the Association for Addiction Professionals. I'll be the organizer of today's event. This online training is produced by NAADAC, the Association for Addiction Professionals and closed-captioning is provided by CaptionAccess.

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2, pass the online CE quiz which will be posted on the website you see here. By the latest tomorrow evening, so try to give it about 24 hours for the CE quiz. If applicable, submit payment for CE Certificate or join NAADAC. A CE Certificate will be emailed to you within 21 days of submitting the quiz.

We are using GoToWebinar for today's live event. Here's some important instructions. So you have entered into what's called "listen-only" mode. That means your mic is automatically muted to prevent any background noise. If you have trouble hearing the presenter for any recommend, I recommend switching to a telephone line, as some intersect connections are not strong enough to handle webinars. If you have questions for the presenter, just type them into the questions box of the GoToWebinar panel. It looks just like the one you see here on my slide. We will gather these questions and if time permits, I will pose your questions to the presenter. Otherwise, we'll collect all of your questions and send them to the presenter so she can provide the answers on a document that will be posted on our website within two weeks.

Now let me tell you about today’s very skilled presenter. Charlene Sears-Tolbert combines her life experience with over 30 years of passionately working in the addiction treatment industry. Throughout her career, she has held many positions with increasing responsibility, including counselor, clinical director, and Director of Research and development. She is currently the CEO of CST & Associates Consulting Firm, leading organizations and a Bachelor’s degree in applied behavioral science and a master’s degree in psychology from the National Louis University, and is in the dissertation phase of her doctoral studies in organizationally psychology.

She is a certified addiction professional and an international board certified addiction counselor. She has had significant training and experiences as a university faculty member that she’s taught psychology courses for the past nine years. We are

delighted to provide this webinar presented by this wonderful professional. So, Charlene, if you are ready, I will hand this over to you.

>> CHARLENE SEARS-TOLBERT: Thank you, Samson. Thank you for the introduction. And good afternoon and thank you to everyone who has joined the webinar. I thank you for taking the time out of your day today. And my goal today is to provide you with some information that can assist you in your organization. Be able to provide trauma-informed services to those in our care.

And we have several learning objectives. And the first one is that you will be able to define trauma and understand the pervasiveness and the effect of trauma on women. The second one is you will identify the core values of trauma and informed care and receive practical action steps to create a more trauma sensitive environment.

And the third learning objective is participants will evaluate their current intake and orientation process through a trauma sensitive lens. So you'll be able to look at your organizations and take an organization process and to determine whether or not you all have a trauma sensitive practices.

I also would like to say before we get started that although this is gender-specific, gender-responsive workshop focusing on women, the principals of trauma-informed care as well as the affected trauma are Universal and can be applied equally across-the-board.

So if you're not in an organization that serve only women, you will still find this webinar very valuable, because a lot of the information applies equally across-the-board.

So, we're going to look at what we have is our first polling question. So I want to get an idea of who is attending the workshop. There's several choices you can choose from. 1 through 5, direct clinical staff. And that is your therapist, your psychiatrist, or providing direct services to the client. No. 2 is executive leadership staff or Board member of an organization.

No. 3 would be operations such as operation techs, correction or probational officers. Support staff would be clerical, kitchen staff, drivers, maintenance. And then No. 5 would be volunteers or others.

And, so, go ahead and enter your response in the poll.

>> SAMSON TEKLEMARIAM: All right, everyone, this is Samson. You should see the poll pop up on your screen. Thank you so much. It looks like we're getting quick responses. Thank you, everyone. This will be one of multiple chances to interact with your presenter today. I'll give you about 10 more seconds to respond.

Perfect, thank you so much, everyone. Three-quarter, 75% of you responded. We're going to close the poll and share the results on the screen and turn this back to the presenter as she speaks to the results.

>> CHARLENE SEARS-TOLBERT: So if we look at the results, I'm not surprised that 57% of you all are direct clinical staff. And I think that that's one of the unfortunate misconception that is we have around trauma-informed care is that it is primarily for clinical staff.

And trauma treatment is directly specifically for clinical staff. The treatment of trauma. But being trauma-informed and being trauma sensitive applies to the entire organization. As a matter-of-fact, clients in residential setting will spend more time with operation staff and support staff than they would with their own counselor. And, so, it's very important that the entire organization from executive leadership, Board members, all the way down to volunteers and your support staff have some trauma-informed care training.

Which you know, and we're going to talk about how that looks in an organization. So, give me just one second. So, what is trauma? And there are multiple definitions of trauma. If you ask 15 people, you may get 15 different answers, and then you of them would be wrong, because trauma is whatever you say trauma is. So it is really up to the individual. No one can define trauma for someone else. It is very subjective. If the person feels this event was traumatic, then the event was traumatic for that person. SAMHSA has a definition. This is sort of our working definition of trauma.

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

And as you see from the picture in this slide, the words on that are, you know, it messes with every aspect of my thought process and functioning. I can be triggered into absolute devastation from a word, the pattern, a smell, or the year. So trauma is very subjective, and it really depends on the person experiencing the trauma. And we're going to talk a little bit more about that as we move through this presentation.

So, Universal precaution: And as caregivers and service providers, we need to really have the perspective of Universal precaution. The same way we do when we handle blood and other bodily fluids, we all have Universal precautions without knowing that person's background, without knowing the person's medical history, we use gloves and other protections to protect ourselves against blood and bodily fluid universally. And the same thing applies to trauma.

It is safe to assume that every person that is seeking our service has experienced trauma. That may or may not be so, but we're better off making that assumption. And treating that person as though they have experienced trauma.

This assumption should also apply to their family members, as well as to agency staff. And that's a piece that we want to pay particular attention to, because oftentimes, individuals that work in service organizations, most of us go into this field because of our own experience, our own trauma, or the experience of a family member. And, so, we all bring our stuff to bare too. We don't leave that stuff home when we go to work. It goes with us into our organizations, and it is with us as we interact with our clients.

And, so, we need to apply this assumption across-the-board and respond to individuals as though they have. Also, I want to make a note that speaking about trauma in a learning environment, like such as this, can trigger trauma responses. So sometimes we're talking about certain types of trauma, individuals participating even on this webinar may start to feel triggered. And you'll know that maybe your breath will get

shallow or quicker, or you become a little agitated, or a little anxious, you have a difficult time being still, and you just feel a little nervous.

And, so, that's quite common even, you know, working with professionals and training on trauma. We see that all the time that the audience will have trauma responses. So it's important as we go through this webinar that you have a couple of mindfulness exercises in mind that you can utilize throughout this webinar to kind of self-soothe and kind of take care of yourself. It's not only important that we teach these things to our clients, but that we're able to practice them as well.

And, so, mindful exercises you can use throughout this webinar would be 7-second breathing. So breathing in slowly for 7 seconds, and then releasing it for 7 seconds. Or really orienting yourself to place so you can look around the room and count colors of objects, how many blue objects you see in the room. So those are things that bring you back into the present.

Body mindfulness, so really paying attention to your body, really feeling your feet on the floor. Really looking at your hands. Just to really bring yourself into the moment. Because a lot of times trauma responses are kind of taken us aback to that old experience. And it's important that we're able to stay focused in the moment as we kind of go through this process.

So I want to talk about the research on trauma. And there has been a ton of research, especially, in the last 10-15 years. But the whole idea of trauma and trauma-informed started with the long-term study on health and social determinants. And they didn't start out looking to do research around trauma. What happened was the Centers for Disease Control and Kaiser health, which is a health organization, they did a study of adults with increased risk for poor health outcomes. Everything from heart disease, obesity, autoimmune illness, cancer, depression, suicide, premature by it, post-partum depression, and on and on and on. And they were looking at, they were studying all these individuals that had these issues. And what they found, they all had in common was that they had experienced, they had Adverse Childhood Experiences, what we call ACEs.

So, all of these individuals had one or more of these experiences. And these are the most common. ACEs are traumatic childhood events. There's certainly many more we can add to this list. But I want to go over the most common ones, because these are the ones that we use to kind of screen our clients and look at what their ACE score is.

So physical abuse. And these are not in any particular order. I want to say that. So there isn't an order to this.

Physical abuse is a traumatic experience. Sexual abuse. Emotional abuse. Having a household member with mental illness especially a parent, it is an Adverse Childhood Experiences. Problematic drinking or alcoholism of a household member. Again, especially a parent.

Illegal street or prescription drug use in the household. Divorce or separation of a parent. Domestic violence towards a parent. That's extremely traumatic for a child to witness a parent being physically abused. It creates a sense of powerlessness that overwhelms their senses.

Incarceration of a household member is also considered an Adverse Childhood Experiences. And, basically, and probably obvious to most of you all that the greater the number of childhood experiences, the more likely that they're going to have some trauma responses that are still showing up as adults.

And, again, we have to remember that most of our clients, their families, and our staff have experienced multiple ACE factors. So very few of our clients come to us with only one ACE factor. They usually have experienced a lot of them.

So the next polling question is:

What do you think is the average ACE score for the female population you serve?

And this applies, again, across-the-board if you're working with men. What do you think the average ACE score is?

>> SAMSON TEKLEMARIAM: All right, thank you, Charlene. This is Samson. I'm going to go ahead and launch the poll. You should see it pop up on your screen now. We'll give you 20 seconds to answer this. Again, you also have the Q & A Box, the connections box if you have any questions. You can send any questions there. It is on your GoToWebinar control panel. All right, 70%. I'll give you 5 more seconds here.

Wow, great so, we're at 78% voted. So I'm going to go ahead and close the poll for those of you who were able to respond and I'll turn this back over to Charlene who will speak to these results for us.

>> CHARLENE SEARS-TOLBERT: Wow, so as you all see, the great majority, 44% of you all said that the population you serve would have 5 to 6 ACE scores. And you're absolutely correct. And which makes this even more urgent and important that we're all trained in trauma-informed care, because we're dealing with populations that have definitely experienced a lot of trauma.

So thank you for your answers.

Let's see. Just one second here. So some other sources of trauma that we don't want to forget about or minimize, because these are absolutely very traumatic experiences. War, military, most of us know about that. That's when most of us ever heard the term post-traumatic stress disorder related to individuals that served in the military. And also serious accidents, illnesses could be a traumatic event.

Witnessing or being a victim to domestic violence, community violence, historical trauma, historical trauma would be something like slavery or the Holocaust, and this is trauma that's passed from generation-to-generation. And the research is actually showing us now that that stuff is passed on a cellular level. Like emotions of anger or fear that can be passed on a cellular level. School violence, bullying, national disaster, incarceration, institutionalization, traumatic grief separation, separation of a sibling or a loved one or death of a someone is traumatic experience. And then there's cultural trauma. There's groups of individuals that as a group experience shared trauma. And an example of that would be the LGBTQ Community and discrimination, and hate crimes towards them.

And they share a common sort of trauma experience together.

So, here is a pyramid that gives you an idea, an overview of Adverse Childhood Experiences and sort of how it affects and influence health and well-being throughout the lifespan.

And the Adverse Childhood Experiences, and certainly the younger individual is when they experienced a trauma, the more the effect of the trauma is going to be. So Adverse Childhood Experiences disrupt neurodevelopment. So when you think about a child, a child's brain is not fully formed. And you know, during those formative of years and there's severe trauma, it may interrupt a healthy brain growth process, neurodevelopment. And we know that neurodevelopment affect emotions and learning ability, and self-control, all of those things.

So that is disrupted with trauma. Social, emotional, and cognitive impairment. Adoption of health risk behavior. Substance abuse. Overeating. Individuals may take these on as a way of self-soothe, but they also become risk factors for bad health. Disease, disability, and social problems, and, finally, early death. So studies have actually shown that individuals with trauma lifespan is shorter than those not if untreated. I'm going to start at the slide of the top left-hand corner.

It affects brain structure. Cognitive development. Social-emotional development and behavior. Learning, ability to form healthy attachments to others and as well as physical health. So this is now science. We have the capability of research, to look at brain scans, to really see and understand how trauma affects brain development and developmental trauma.

So in a typical brain development, there's a survival mechanism that is our reptilian brain, the part of our brain, the life or death part of the brain that, you know, takes care of us, right? That took care of our ancestors in the jungle when tigers, and lions were chasing them. That survival. That doesn't require any cognitive ability. And a typical development, that's actually the smallest portion. And then you have regulation, social-emotional abilities, and cognition. So the ability to kind of think things

through and rationalize, and higher order thinking. You know, that's part of our cognitive reasoning ability that we develop as we get older. That's typical brain development.

However, with developmental trauma, what you will find is its really upside down. The survival mechanism and a person with developmental trauma is the greatest part more affected on them than any other part of the brain. So it overrules the regulation, their social-emotional, their cognition, their cognitive reasoning ability doesn't operate as well as the survival skill, the life or death, the constant feeling of "I am in danger." "I'm going to not be safe." So they're hypervigilant. They're not trusting. The world is not safe. People are not safe. And, so, they're constantly operating in the survival mode. And we know what happens to the body when you're constantly in that mode. Your body is producing all of these stress hormones and cortisones that become detrimental.

And also people who experience trauma as adult, they're more likely to commit suicide, 15 times more likely to commit suicide. They're four times more likely to become an alcoholic or have sexually transmitted diseases, or inject drugs. And, so, we see that trauma increases an individual's risk factor in a lot of areas.

And, so, again this is a slide, you know, looking at the process of trauma. Like what happens when there's a traumatic event. And then there is a response to the trauma. And usually, you know, in a traumatic event, it overwhelms the physical and psychological systems, right? There's an intense fear or helplessness, or horror, you know, something usually out of your control, and you have no control over what's happening.

And, so, our response to that is those kind of survival mechanisms that is fight or flight, or freeze, or a lot of times, individuals may go into an ultra state of consciousness. They may detach from what's going on, like out of their body, kind of detached, or numbing, or becoming hypervigilant, or hyper-arousal. So there's a number of things that happens as response to trauma. So that affects the nervous system in the brain. And it literally changes the brain. And that trauma, especially, in early childhood literally changes the brain and the way that the brain is developed.

And there's usually one of three ways that individuals deal with trauma if they haven't gotten any help and their trauma is unhealed. They either retreat. They have the isolate. They dissociate. They become depressed. Or they have a lot of anxiety. Or they take on self-destructive positions like drugs or harming or they act it out through aggression, violence, and rages.

And, so, once again, trauma is subjective. And I may say this a few times because I feel it's very important we understand that. Because a lot of times, we may feel someone's trauma is trivial. And it may trivial to us, but it may seem very real to them.

So the 3 E's of trauma is the event. An event happens. And then there is the experience of that event. What I tell myself about that event, the narrative that I have about that event, what I think that event means about me. Right? So that is the actual experience of it, which is separate from the event.

And then based on the experience of the event, there is an effect. Right? So it begins to take on an effect and we begin to develop responses to it. But trauma is really about the experience rather than the event. It's really more about how the individual see that trauma. What lens do they look through because of that trauma? And, so, that is why it's very subjective, and we really can't compare. You have two individuals experience the exact same trauma, and they're the exact same event, and one may be traumatized and the other one may not be traumatized by it. But that's because they bring to bare to their situation their own world view, their own life experience, their own belief system. So a lot of things go into play that determines what the experience of the trauma would be.

So let's look at females in trauma. Women are twice as likely to develop PTSD than men. I think most of us know that women have higher rates of sexual assaults. 14-20% of women will be raped at least once. And an alarming number, 25-35% will have experienced sexual abuse in childhood. So that's anywhere between 1 and 4, or 1 and 3 women. Okay? So if you're sitting in a room right now and there's more than 3 women, pretty much almost guarantee one of them have had an experience with sexual abuse in childhood. And it is extremely prevalent impaired brain functioning, so survival

mode: Flight, fight, freeze. And the fourth one is really more men do it too, but women especially. And that is fawn. And, so, fawn is like you go into action, but you kind of go into caregiver mode in order to manage your own trauma, and in order to self-soothe. So you take care of your mother when she's drunk, and you take care of your sibling and you make sure everyone is okay. And you adopt that as a way to survive, as a way to survive, you fawn over other individuals. And you meet other people's needs rather than tending to your own and looking at your own trauma. So that's a response to trauma.

Responses to traumatic stress are adaptive: You know, everything from withdrawing, aggression, spacing out, substance abuse, cutting or other self injurious behavior. They're all adaptive.

Females and trauma. So women generally have layers of relationship wounding. You know, starting from their early childhood maybe with their father and their mother, but also women, because women are very relational, more relational than men most of the time. Women will enter into relationships and often they're in unhealthy relationships when they have trauma development, because of the impaired brain functioning, they're not able to make the healthiest choices. And, so, then they're wounded, and it creates a vicious cycle of choosing an unhealthy relationship and being wounded. And not just in intimate relationships, but even relationships with co-workers and friendships.

So they have layers and layers of relationship wounding. They typically lack trust. And they're hypervigilant and hyperreactive. And women, especially, women with substance abuse issue with overwhelming guilt and shame, more so than men. And primarily, that's primarily because, you know, society expect the women to take care of her children and be a mother to her children as much more of a burden placed on the women to do that than a male. And when a women is in addiction and she's unable to do that, that brings an incredible amount of shame if she's had her children taken away or she has to sell her body sell for prostitute for drugs. So this is on top of top of top of guilt on shame. And women tend to internalize their emotions. They have high anxiety. They worry about others. There's fawning.

And this is a sensitive one, but we have to talk about this. Women are often triggered by male staff, especially, working with women with substance use issues. Because a lot of their experience with staff has not been healthy experience. But that, too, can be a learning opportunity. That doesn't mean you don't hire male staff or you shouldn't higher male staff to work with women. Absolutely you should. It's an opportunity to give the women an experience of a safe man. So you want to make sure you screen the males that are working with female clients, because they can provide the greatest opportunity for growth for women with regard to their issues with men. Because a lot of them have never had the experience of a safe male.

And I know when I was the Executive Director for an organization, and I have clients put in requests, and I always had a male staff on. It was still a women's facility. And I got request from women asking to change counselors because he was a male, and he was triggering her. And I rarely, if ever, would change counselors. So I would talk to the woman. I would hear her out. I would validate what she's saying. And then I would mediate. I would have her sit with the male staff in my presence and talk about, you know, all the stuff that was coming up for her. And have the male staff, you know, offer her support. And it's important that your male staff don't become defensive because of female client has been triggered. Because it really has nothing to do with him, but it has everything to do with her experience and the men in her life. So that's an important piece.

But really encourage them to give this an opportunity, because it could be a great healing opportunity.

So what is trauma-informed care? And once again, I want to say it is not the healing of trauma. So, that's that misconception. And that is why mostly clinical staff attend trauma-informed care workshops. Trauma-informed care is not about the healing of the trauma or dealing directly with the client in addressing her trauma. Rather, trauma-informed care is about an approach to delivery of services. So it is the delivery of services that include an understanding of trauma and the awareness of the impact that institutional processes and individual practices can have in re-traumatizing clients.

So it's really about a delivery of service. Organization-wide. Trauma and trauma-informed care changes the question from "What's wrong with you?" To "What happened to you?" So it's a realization that the clients we work with have experienced trauma. A lot of them have experienced significant trauma. 5, 6, 7 or 8 scores on the scores. And, so, it's really about operating from that place no matter what your role in the organization is. If you're the receptionist and you're the first person to have contact with that client when they walk in the door, it is very important how you respond to that client and how you treat that client. And that is what trauma-informed care is about. It's about the organization and how the organization responds to individuals that have been traumatized.

Assumptions about trauma-informed care is the 4 Rs. And first R is realize. We want to realize the widespread impact of trauma and understand the potential path for recovery. There is recovery from trauma. But we want to realize that it's very widespread. And you know, even this webinar, looking at the ACE scores, I'm hoping we're beginning to understand just how widespread trauma is. The other R is recognize.

And, so, that's recognizing the signs and symptoms of trauma in clients and families and staff. Again, we have to look at staff and looking at staff's own trauma and how that comes into play in the work environment. Because it definitely comes into play in the work environment.

The other R is responding. We want to, as an organization fully integrate knowledge of trauma into your policy, your procedures, and your practices. So if trauma-informed care is not written into your policies, then your organization is really not trauma-informed, because it's something you have to have buy-in all the way at the top, all the way throughout the organization that we are a trauma-informed organization. And these are some of the things that we do as a trauma-informed organization.

This is what it looks like at our organization. And that should be in policies. And it should be in your procedures. And, finally, we want to resist re-traumatization. Right?

So consciously seek to actively resist re-traumatization. So, we have to be conscious about it. We have to remind ourselves that we're working with a population that have been very traumatized, and, so, we need to be aware consciously of what we're doing individually so that we don't re-traumatize the individual that we're working with.

So, oops, I'm sorry. I got a little ahead of myself. I will go back a slide. So, I want to talk and do a little exercise. This actually works better when I do this workshop in person. But I want you to think about kind of stranger danger. And in our condition response to strangers. We've been really conditioned to be leery, be weary, don't talk to strangers.

So imagine a stranger just asked you this question. "How many sexual partners have you had?" How would that feel if your co-worker asks you that? If your boss. Even not a stranger but someone you know asks you that question. That's pretty invasive, right? It's pretty invasive.

"Have you ever traded sex for drugs or money?" And someone you knew asked you that, that question would feel very invasive.

"Have you ever tested positive for any STD?" How would that feel to be asked?

"Were you ever sexually abused as a child?" And women who were sexually abused never ever talk about it. Never ever talk about it. So someone asking that question, especially, if there's sexual abuse in your history, how would that feel?

"Do you have H.I.V?"

"When was your first sexual experience?" How old were you when you had sex? Have you ever been forced to have sex against your will? So if you have been forced to have sex against your will and you have someone asking you this question, a stranger no less, how do you think that would make you feel?

What about: Have you ever practiced self-mutilation? Self-mutilation is often a very shameful thing that, you know, happens. And, so, having someone, a stranger ask you about something that's secretive, something that you try to cover up and you try to hide can be very overwhelming. It could trigger a lot of different response.

Have you ever been accused of abusing your child? So imagine a mother being asked that by a stranger. Have you ever been accused of abusing your child?

And our next poll, I really want to know how comfortable would you be if a stranger asked you of the previous questions I just went over. How comfortable would be from 1 to 4?

>> SAMSON TEKLEMARIAM: All right, everyone, and this is Samson. So the poll will launch right now. You should see it pop up on your screen. You can interact with the presenter by using this poll question here. And you can also send any questions you have in our questions box which is on our GoToWebinar control panel. Thank you to those who have sent in questions. I will give you about 10 more seconds. It looks like more than half have responded.

Excellent. So we just hit 75%. That's great. So I'll go ahead and close the poll. That's close to 200 responses. So I'll share the results here on the screen. And turn this back over to Charlene.

>> CHARLENE SEARS-TOLBERT: So, again, an overwhelming majority, 54% said extremely uncomfortable. And then, you know, close to that 33%, somewhat uncomfortable. There were 7 neutral and a few people was very comfortable. They said they would be comfortable being asked those questions. And I always asked this, because this is important to note that every question that I just ask in the previous slide, we ask our clients those questions during their psychosocial assessment.

And the psychosocial assessment is usually conducted within the first week that a client is in the program. So, there isn't a relationship developed. You know, you're not relational. There's no relationship developed. But at the same time, you're asking some of the most detailed deepest questions. And a lot of times, you know, even when I was a counselor, I fell into this. You become desensitized almost asking these questions. They don't carry any weight. Were you ever sexual abuse and then you move on to the next question. But we have to remember, for some of our clients, they've never been asked that or they never answered that honestly. So we really want to honor that. We want to honor how invasive some of our processes are.

It's not that we're going to change our process, but we're going to operate from a place of consciousness and from a paradigm of understanding that these questions are extremely invasive. And we can offer that to our clients, you know, and say, I know some of the questions are going to be uncomfortable. You know, I want you to do your best to answer. Just acknowledge what they're feeling. If you pay attention to their signs of distress, so you can respond to that. Allow breaks. Offer them a glass of water to help them feel better.

So, trauma has a pervasive and harmful impact. And most institutions and service systems have historically exacerbated or unintentional re-traumatized. And that's intentional. And it is not our intent to do harm. I started working in this field in the '80s, in the late '80s. And some of the practices that we had back then, they were the exact opposite of trauma-informed. You know, especially, in addiction. It was really confrontational, in your face. And when I think about that sometimes, it makes me want to cringe. But we didn't know any better. We honestly didn't know any better. I was taught in my early days as a counselor that you had to be confrontational with an addict or they wouldn't respond to you. I thank God that times have changed and information has changed. And science, we now have the science that let us know that that system doesn't really work. That we really need to operate from a trauma sensitive place.

Some of the impact on clients is loss of trust. Less willingness to participate. And this is the impact on clients of being re-traumatized in our organization. Either through something someone said or it could be the way someone looked at them. They lose trust. They don't want to participate. They may act out in self-injury or they may relapse and start using. We have a higher dropout rate. Clients may have invasive thoughts and flashbacks. And, literally, get physically ill in response.

And it also has an impact on staff. So, distrust of management. Increased in work related stress. Higher rate of turnover and low morale. Increased staff illnesses and absence, and then burnout. And this impact on staff is really what happens when the organization is not trauma-informed. And, so, we're triggering the clients, and then the clients are, in turn, triggering staff. And, so, you have this whole situation.

So, let's start moving into the solution and look at some of the key principles of trauma-informed care. And we'll also look at some practical approaches. And, so, across-the-board, and it doesn't really matter what population you're dealing with. There are five key principles of trauma-informed. And the first one is safety. Both physical and emotional.

The second one is trustworthiness and transparency.

Collaboration and mutuality.

No. 4 is empowerment, voice and choice. And No. 5 is cultural, historical, and gender competency.

So let's look at safety -- physical and emotional. So in order to be trauma-informed, a trauma-informed organization, you want to provide an environment that assures emotional, physical, and psychological safety. Excuse me.

You want to have clear rules in place, because that actually provides that safety. You want to have processes in place to deal with clients' grievances or needs. And you want to make sure you're providing an environment that psychologically and emotionally is safe.

Prepare women to be overwhelmed. And this is something, you know, we could do a lot more of in our organizations, because a lot of times, we do the opposite unintentionally. We say it's going to be okay. Don't be upset. You'll get through it. When women come into our program, they're overwhelmed. And it's important that we have to normalize their emotion that I absolutely know this is a very overwhelming process for you. That this experience is very overwhelming.

So we simply acknowledge that. We normalize their emotions. You know, we know the treatment and incarceration, having a Child Protective Services, all of those things are extremely stressful. So we actually validate it and let them know what they're feeling is normal.

Identify a "Safe place." And set some parameters around the safe place. So the safe place could be a chair in the dining room. And you know, the clients can get creative and decorate it. If it's not a residential environment, it could be a different seat

inside of the counselor's office or some bean bags on the counselor's office. So if the client is feeling really overwhelmed, really stressed, emotionally, and they're starting to feel trigger responses, they can go to that safe place.

And you want to set parameters. You can stay in the safe place for 5 minutes. You want to set that up in advance so they know what the parameters are. But it also helps them to feel like they have a choice in the matter. And that they are part of this process. And they are able to, if things get too overwhelming, to remove themselves from it, even if it's only a few feet away from where they're sitting is like they're able to do something about it.

Have a clear process for handling conflict. Know what the process is and post it throughout your organization, whether it's a grievance process so everyone is aware of what that process is.

Trustworthiness and transparency. It's really about being consistent and accountable. So consistency and accountability, like follow-through. We know that our clients watch us, and they're looking for us to fail. They're looking for us, especially, when they have trust issues, they're looking for the flaw where they can no longer trust us. And one of the best ways to build trustworthiness is to be consistent and be accountable. Follow-through. If you say I am going to find out an answer to a question, follow-through. Circle back.

Even if you don't have the information, say I'm still working on it. Provide information on the process. Be transparent about the process. You know, if you're doing intake, and you know intake is going to take 2 hours, and it's going to be grueling. Provide information on that. You know, this process may take couple of hours. We'll be able to take breaks as you need them. You know, provide information so they are aware what's going on.

And, really, be authentic. Really be authentic because you're interacting with clients and clients don't care how much you know until they know how much you care. And that's really one of my favorite quotes working in social services. Because that is

what it comes down to. They're looking to see if you're safe. If you care enough about them. If you're going to do what you say you're going to do.

Collaboration and mutuality is very important. Because the client is the expert in her life. So we want to engage her. We want to ask for her feedback. We want to include her in her treatment goals and all of that. And we don't want to just give cookie cutter treatment goals, right? We want to ask her thoughts. If you're working in a residential facility and you're able to establish clients, it's important, because it helps the client feel like they have a stake in what goes on inside the facility.

You know, we want to include clients in major change or decisions that involve them. You know, visitation change or something like that, you want to make sure that you're communicating. Clients should have access to administration if they need to speak to administration that they will have access to that individual.

Empowerment, voice and choice. This is really about recognizing strength and resilience. Although our clients have multiple ACE factors, they also obviously have multiple resiliency factors. Because they have been able to survive the trauma that they've gone through. And although some of those survival skills was acted out in a negative way, we can actually begin to teach them how to use those skills for their benefit.

Wherever possible, we want to offer a choice. Even if that's what would you like? If you walk into a room and there's a conference table, sit wherever you like to. Just giving them a choice is very empowering, because for so many of our clients, they have lost their ability to choose anything. So wherever possible, give them a choice. You know, if you're doing an intake session or something, you can say, would you like to break in an hour? Or would you like to go on for the 2 hours? And give them a choice in it. You know?

And allow women to tell their story. Validate her trauma. A lot of times, trauma needs to be heard, right? So we just want to validate her trauma. And that is not saying by any means that a non-clinical person should, you know, try to help a client heal her trauma.

What I know is, especially, in a residential environment, women will often start telling their stories to operations staff, and to other people other than their clients. And it's important for them to validate it. And then inform her counselor so that the counselor can help her work through that.

Allow personal decor and sleeping areas, and pictures of children. Make it personal. Let them feel empowered by it. They have a voice in their living arrangements. Also cultural, historical, and gender competency is huge when it comes to trauma-informed care, because those are some of the areas we can be the most wounding.

So it's important to have proper training to all staff on culture competency. It's important that we recognize our own bias so that we can respond differently to them.

We all have them. It's important to recognize what they are. Display multicultural art and decor in your organization. So that when women enter into it, they feel the sense of inclusion. And celebrate all cultures. You know, even if you're an outpatient center, you can put up decorations for all different cultural holidays and, so, it feels more inclusive.

So, the first 72 hours. There are a lot of protocols that demonstrate that first 72 hours is very critical. This is a very critical time in almost any major process, right? So when there's a traumatic injury, like the protocol around that is that if they're not responding within 72 hours, the chances begin to decrease that they are going to respond.

Emergencies and natural disasters, they have you prepare for the first 72 hours after that disaster happens, because that's the most important time is usually within the first 72 hours. That's the crisis time. That's when all of that is happening. The same thing with search-and-rescue missions. If they don't find a person within 72 hours, that's usually like the cutoff time that, you know, the chances decrease that this person is going to be found and reentry from jail or prison and relapse prevalence protocol. The first 72 hours, what they do within the first 72 hours when they leave our program or leave jail is going to be huge. And also the military has a protocol. I had a video, I'm

not going to be able to show it during this webinar that talks about the military's first 72 hours when a new recruit joins the military. The things that should happen.

Because during that time, you know, you're still a stranger. They don't know you. So there's an opportunity for all kinds of triggers. So let's look at what are some possible triggers could be within the first 72 hours of a client seeking your services.

So feeling ignored, so she's sitting there in the lobby and people are walking by her and talking and laughing. And no one is paying attention. They're not getting -- she had a 2 o'clock point and it's 2:30 and still not seen. Lack of privacy. Staff talk to the client about other people about personal or not personal, but feeling like they don't have privacy. Feeling pressured. Feeling forced to do something. Sitting somewhere and have other people whisper and you know, they don't know what you're whispering about. Arguments. Being isolated. Or being touched. That could definitely trigger a trauma response. Very loud noises. Loud music. Or being stared at by other clients or other people in the organization could trigger trauma.

Body and property searches. Definitely, this can trigger trauma. So these are things, and I feel we have to do in the safety of the program, and the safety of the client, but we can do it in a way that's trauma-informed lens. And that is simply communicating that I know this is invasive, but this is something I have to do. Kind of talking through that process and letting the client know that you understand. So, again, it's validating experience. When you're validating, you're not re-traumatizing. When you're just grabbing them, you know, move this, move that, bend over, that's re-traumatizing. But when you're validating, then you're saying I know this is uncomfortable, but this is what we have to do. This lessens the risk of re-traumatization.

Room checks. Going through all their personal belongings can be traumatic. Having contact with family members or their children. If they haven't spoken to their children in a while, they feel all this guilt, that can be traumatic. Intake questions can be very traumatizing as we just looked at. Interacting with male staff as we talked about could be traumatic. Telling a client "Trust me." You know, usually, especially, when someone just meet you and they say trust me, there's a tendency not to trust. So you want to avoid saying that.

Certain smells could be triggering. And just the whole idea that I have no control over what's happening right now is triggering.

So here's some practical approaches to trauma-informed care within the first 72 hours. So, in terms of the environment, so this is very important. And this is where it comes back to the organization. This is not about the clinical services. This is about the environment. So you want to have an entry sign that feels very welcoming. Even from the time the individual pulls into your parking lot, they begin to make judgments about your organization.

And, so, you want to have clean and well-maintained office space and building inside and outside. Multicultural art displayed. Soothing colors for decor and paint. And overall quiet, soft music. Especially, where you're doing intake, you want to make sure that it's soft, you know, soft and quiet. You want to have neutral or pleasant aromas.

When I was running a women's organization, we had intake on Tuesdays. And the kitchen staff cooked cabbage. And, so, I had a bus load of women coming in on that day. And when they first walked into the building, it was like oh, my God! The smell was horrible, so we learned not to cook cabbage or anything like that on intake days so we would have a more pleasant aroma.

Living decor. Remember women are caregivers and they're fawn. So they like to take care of things, so if you have plants or fish they can feed. And always have private screening and intake areas. And try not to treat a client like they're on an assembly line. And I know if you have an organization where you only do intake one day of the week, and, so, you have multiple people to intake. Really figure out a system so that there's as much privacy as possible.

Have a child-friendly play area if possible. Even if it's just a little tiny table in the corner with coloring books and crayons on it to help the women feel like, okay, she can see her child here.

Therapeutic signs and posters throughout the facility. And offer clean clothes and toiletries immediately either to residential facilities, because oftentimes, they come

and they may come to us from jail or other places, and we want to have clean clothes and toothbrush and toothpaste and shampoo ready for them, because they may not have that. And assign peer support. If you're in a facility where you can have a client that's been there longer, kind of take her on a tour of the building or something like that. Someone that can answer her questions that's a peer support, that's very important.

Staff appearance is important to client's safety and how they feel about being in the program. So staff's attire should connote professionalism. Staff should dress in a professional manner. And I know in a lot of our environments, we dress more comfortable. But you don't want saggy jeans or anything like that. There needs to be some assemblance of dress code. Staff should be easy to identify from clients.

So, that could mean all of the staff wear a lanyard. Or I'm sorry, if the clients wear a lanyard, does staff wear a different color lanyard? That's easy to identify who is who. Make sure the staff has good hygiene and good grooming. And that your clothing is not sexually provocative because that could be a trigger for women.

Staff behavior. You want to initiate warm greetings, introductions, you know, speak to them as though you're happy that they are there. Be genuine. Be authentic about it. Ask the client what name she would like to be called. You know, she may not -- she may go by a different name. And you want to honor that wherever you can. Some programs understand, especially, some criminal justice programs don't allow that. But wherever that's allowed, you want to do that. Speak in private whenever possible. And respond to requests for help. You know, if the client asks for help or asks a question or needs something, respond to that. And always speak in clear, even tones. Make eye contact and smile. The clients are looking at you.

Make every effort to minimize delays. And even if you do have a delay, create predictability. Set timeframes. Say, this will take 2 hours. Or this will only take 30 minutes. Or we're going to be delayed for another 30 minutes. Create some predictability so she doesn't feel so powerless.

Offer sincere compliments. If there isn't something sincere that you can offer a compliment, then, you know, we don't offer them. But even like, wow, I appreciate you

came on time today. Something like that. And you want to provide as much information as possible about the intake and orientation process so that they can know what to expect. Again, the predictability goes a long way. Having an understanding of what's going on because, remember, again, it's a very invasive process. But we want to help them understand as much as possible.

Pay attention to body language. And respond to signs of distress if someone is rocking or crying, then they're clearly in distress. That would be the time to bring in a clinical staff member to maybe speak with that person and see how they could support them.

Offer cup of water or something simple as that. Really humanizes the client that they're not just, you know, offer a glass of water when you're starting your intake. Would you like a glass of water? If there's another beverage available, would you like a cup of coffee if it's in the morning time? You know, and validate the client's experience. Understand that you have been through a lot. And this was very difficulty getting to this place. Just validating that.

And searches and squats. We have to be sensitive to the invasion of privacy. We have to do it, but we want to be sensitive to it. We want to acknowledge that in the process of doing it, we want to say, I understand this is invasive, but this is what we have to do. And you want to be sensitive about it. Because it is extremely invasive. Offer sanitary products. Offer clean clothing and toiletries as soon as possible. And wherever possible, host a staff meet and greet with the client that's coming into your program so they can have an opportunity to see who the staff members are.

So we have another polling question. How would you rate your agency's current integration of trauma-informed care approaches? And we have 1 through 4. And Samson is going to do our polling question.

>> SAMSON TEKLEMARIAM: Thank you, Charlene. So this will be our fourth and final polling question. You can also ask our presenter questions in the questions box that you can see in the GoToWebinar webinar control panel. I'll go ahead and

launch this final poll here for you to interact with our presenter. And give you about 20 seconds here to respond.

All right, thank you, everyone,. We're going close the poll here. We've got a bit over half of those responded. And we'll share the results and turn this right back to Charlene.

>> CHARLENE SEARS-TOLBERT: So, great. So we have a lot of you all, 44% who has partially integrated TIC practices. And that's wonderful. Just starting that process is incredibly important. And there's value to our clients. And I see there's a large 31% partially integrated, but without a clear plan on how to move it forward.

So simply having a Trauma Informed Care training is really not integrating Trauma Informed Care systematically as part of your organization. So we will look at, let's move to the next slide.

So, looking at some other things that your organization can do to increase their trauma sensitivity across the Agency and working with clients that you serve. Review the structure and assess aesthetics of the facilities. Try to look through the eyes of the person coming there for the first time. It's important that every organization that wants to become Trauma Informed Care, they identify a trauma champion. So that's going to be an individual in your organization that really helps to move it forward. They kind of keep track of trainings and activities and events, and kind of follow-up on any type of assessments that are done in terms of the organization being trauma-informed.

Conduct a program self-assessment. There are a lot of tools out there, and in my reference section, there are some tools in there as well that you can use to conduct a program self-assessment that you can really assess your program in a lot of different areas to see how you're doing in terms of being trauma sensitive.

Identify training needs and provide training to all staff. I can't stress that. It's important that all staff receive Trauma Informed Care training. Not just your clinical staff. And a lot of times, it may be necessary to bring in an outside trainer if there's any resistance or if you're thinking this is one person's agenda. Sometimes it's better to bring in an outside trainer. You want to implement trauma-informed practices,

especially, with non-clinical staff. So you want to have practices in place that seek actively not to re-traumatize.

Evaluate program's progress. You want to constantly evaluate. Like anything else, quality management, you know, you have to constantly evaluate how we're doing, what we can do well and better. Utilize Trauma Informed Care resources and stay current. There's so much resource out there now. Just a quick Google search will turn out tons of thing you can do and stay current with the research around Trauma Informed Care.

And understand how trauma impacts both clients and staff interactions and responses. Again, that's very important, because staff is not able to leave their trauma home when they come to work. And a lot of times, clients triggers can trigger staff and create negative interaction. And, so, we want to be aware of that and conscious of that so we can seek not to re-traumatize in that way. Encourage staff to care for themselves so they can care for others, a self-care plan.

Any true systematic Trauma Informed Care includes the staff. Staff has to have a self-care plan. And a lot of times, it can be included in their evaluation, you know? How are they taking care of themselves? What are they doing outside of the work environment in order to have that balance so they're able to manage distresses of the job?

And understand vicarious trauma and compassion fatigue. And that's a whole another webinar. But it's really important to understand that even if you don't have trauma experience, you know, vicarious trauma happens when you're listening over and over to the trauma of someone else. And you can have the same kind of reaction, the same kind of feeling in your body as though that trauma happened to you.

So it's important to understand vicarious trauma and the work that we do, as well as compassion fatigue. Giving, being a caregiver, and giving and giving and giving and not filling yourself up. And, so, self-care is very important. So we're not just giving, giving, giving, but we also have a way to replenish that energy and take care ourselves as well.

So, we have just a few more minutes left. And I wanted to be able to take couple of questions if possible. Do we have any questions?

>> SAMSON TEKLEMARIAM: Hi, Charlene. Excellent webinar presentation. Thank you so much, and, yes, we do have a lot of questions coming in. And, yes, we do have some time so we'll take some questions here. Any questions I don't get the to with Charlene, just know that they will be sent to her in a Q&A handout. And that page will also include the YouTube video clip for the military video, the first 72 hours. Really great video clip. That will also be on the Q&A page for those reviewing live and for those viewing online demand. So Charlene, our first question comes from Lisa from Little Rock. Little Rock, Arkansas. She asks: Are there degrees of trauma?

>> CHARLENE SEARS-TOLBERT: There are. Well, there's trauma, and then there's complex trauma. So if anything, that will be the degree. There isn't like 1, 2, 3, 4. But there is a difference, a clear difference between trauma and complex trauma. Complex trauma happens when one of the ACE factors is happening over, and over, and over. And, so, sexual abuse, if your sexual abuse once or sexually abused daily, that constitutes as what we refer to as complex trauma. So I hope that answers your question. So, obviously, with the ACE score, there can be varying levels depending on the number of your ACE score as well.

>> SAMSON TEKLEMARIAM: Excellent, thank you, Lisa for the question and thank you Charlene for the answer. Anna Ripley asks, there's a lot of information. I'll just read it for you. Gender informed. So for women who are clients, can we consider using terms more current such as people who identify as women, female, fem, I believe women who are MFT trans and as well as other sexual identities. It's a simple shift in language. Do you ask our clients what pronouns and names your client prefers?

>> CHARLENE SEARS-TOLBERT: Currently in the organization that I worked in most recently, we did not. But I certainly agree with you that we have become more aware and more sensitive to that. Like, that's certainly where it's allowable. Because my most recent, I worked for a criminal justice facility that did treatment. So there's some limitations to that when you're working in the criminal justice environment.

But, however, I think we absolutely need to be cognizant of that. We certainly ask questions around, you know, sexual preferences and gender identification. But that's a great point. And I think it's something that we need to incorporate more and more in our work.

>> SAMSON TEKLEMARIAM: Excellent. Thanks, Charlene. And Anna Ripley, thank you for the question. Those still sending in the questions, thank you, keep them coming. We will answer them on the webinar or the Q&A handout that will be posted on the website in about a week or two. Next question comes from, let's see here. Helen Tufell. Helen asks do some people do not remember for sure or know if they were sexually abused as a child?

>> CHARLENE SEARS-TOLBERT: Absolutely. Not everyone remembers of a lot of times, sexual abuse can take place preverbal before a child is able to talk about it. We know people abuse babies and toddlers. And a lot of times, as a protection, as a defense mechanism, as a protection against the trauma, we could block it out. Like block out the fact that this ever happened and it's deep, deep in the recess of the mind. So absolutely. That is a very common response that detach from it, block it out, it never happened.

>> SAMSON TEKLEMARIAM: Great. I think we have time for two more. So I'll go to it. Helen, thank you for the question, Helen from Gainesville Florida. Charlene, thank you for the answer. We have 2 more. Cynthia Hudson asks, Cynthia from Colorado asks, would you recommend SAMHSA tip 57 publication on Trauma Informed Care?

>> CHARLENE SEARS-TOLBERT: That's the premiere Trauma Informed Care. So everybody should have a copy of it. It's free. You can call. They were sending out manuals. Sometimes you have to print them off, but absolutely. Every counselor should have a copy of it.

>> SAMSON TEKLEMARIAM: Agreed. Thank you so much. And Cynthia from Colorado, thank you for that question. Last is from Dana Allen. Dana asks, she's saying something about her background, our participants are required to attend AA

meetings some of them who have significant trauma from religious entities are against this. How do I approach the judge that not everyone can participate in AA even though it claims it's not religion based? How do we help our patients with this?

>> CHARLENE SEARS-TOLBERT: I think offering a viable alternative, and presenting that alternative to the judge. So just going to be the judge and saying, you know, they can't do this without offering an alternative may not work very well. But if you have a viable alternative such as some type of in-house support group that you can offer to the judge instead, then that may work.

>> SAMSON TEKLEMARIAM: Wonderful. Thank you so much. Charlene. Everyone, thank you for those questions. Charlene has a list of references and resources. And, again, thank you Charlene for this excellent presentation.

>> CHARLENE SEARS-TOLBERT: Thank you.

>> SAMSON TEKLEMARIAM: Everyone, just a quick reminder that everything you need to know about the particular presentation is on the NAADAC website. You can watch the recording after the live event, download the PowerPoint slides, take the CE quiz, and make a payment if you're not a NAADAC member. The web address for this webinar, again, is www.naadac.org/gender-responsive-trauma-informed-care-webinar. You can go to this page in the future when you need information related to this webinar. And as a reminder, here's some quick instructions for receiving CE credit.

For those who missed the introductory statement, if you wish to receive CE credit for attending this webinar, you must be registered and listen to the entire webinar. Also, passing the CE quiz, that will be located at the website you see here within about 24 hours or so.

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Also at the close of this webinar, a pop-up will show as a survey or a feedback tool for you to give us a quick feedback to evaluate this webinar and your training experience today. We would love to hear from you and hear your feedback on how this webinar went for you. We're constantly working to improve the online educational experience. And we will share the results of your feedback directly with our presenter today as well.

For those of you interested, here is the schedule for our upcoming webinars. Please tune in if you can, as they are some really interesting topics just like today with some great presenters.

And if you have not done so already, go ahead and bookmark www.NAADAC.org/webinars. For those local experts and specialists in tools or treatment methods that you feel like you really would love to share, or if you are an experienced presenter yourself, please go to our website. The deadline for the 2020 call for webinar proposals is July 16th. So coming up very soon. Only about 5 or 6 more days. That is the website to go to the find out information about how to submit a proposal. Www.NAADAC.org/call-for-webinar-presentations. The remaining of our 2019 webinars have already been scheduled. And we have launched this call for webinar presentations. And it will be decided upon towards the end of this year. So we will have our 2020 schedule up towards the late fall or early winter of this year.

Just remember as a NAADAC member, this is a quick review of the benefits of becoming a member with us. If you do join NAADAC, you have access to over 145 CEs through our free educational webinars. You also receive a quarterly advances in addiction recovery magazines, where each article is eligible for CEs as well.

NAADAC offers in-person seminars throughout the U.S. and internationally, and also included in the NAADAC membership are independent study courses, regional, annual conference benefits, certificate programs, and more. Check out our website or connect with us on social media. You can stay connected with us through LinkedIn, Facebook, and Twitter.

Charlene, thank you so much again. And everyone thank you for participating in this webinar. I encourage you to take some time to view our website and navigate and just learn more about all the additional resources we provide. Have a great day, everyone.

>> CHARLENE SEARS-TOLBERT: Thank you, everyone.

[End of webinar]