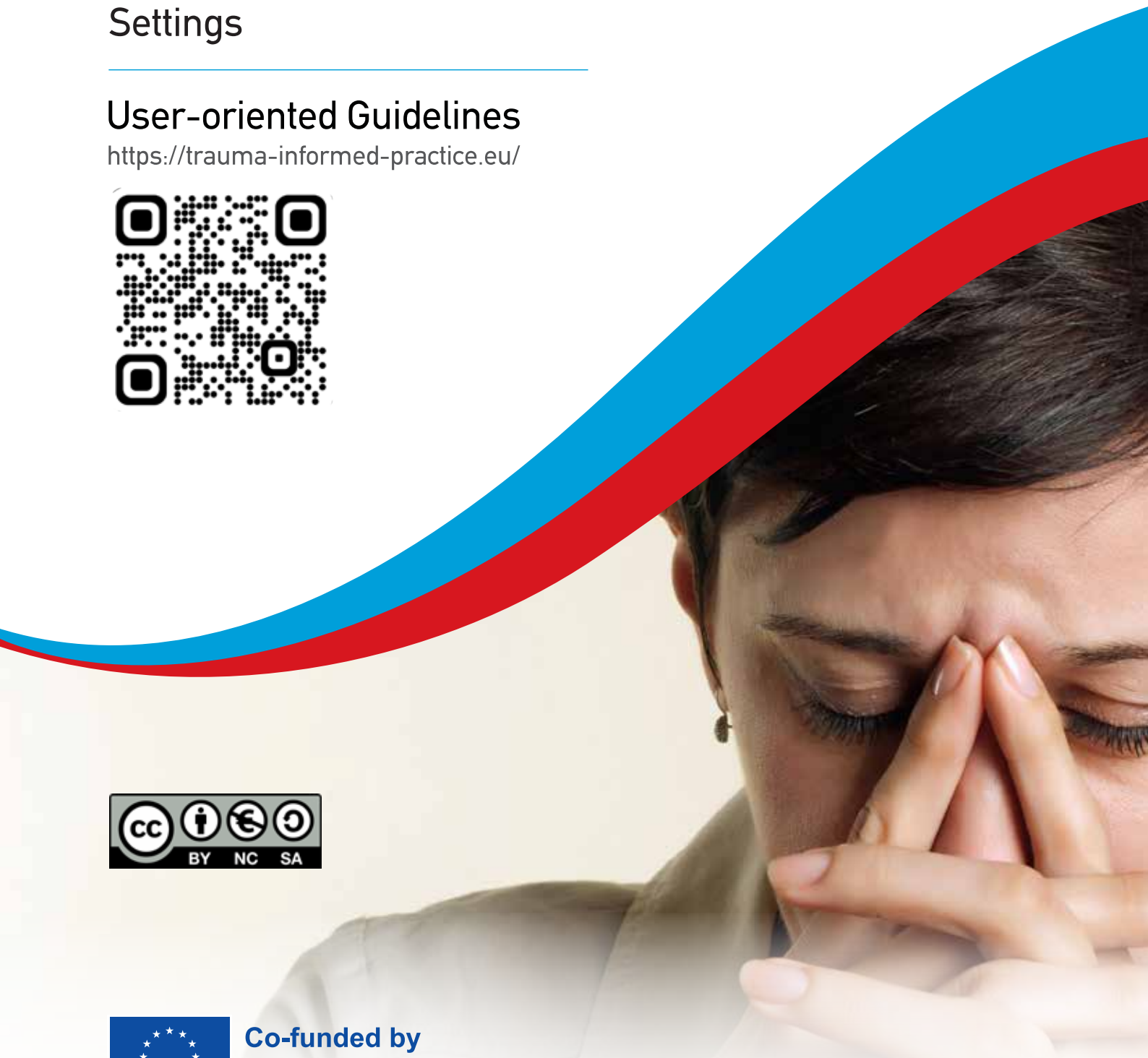
TIPS

Trauma-Informed Practice for Workers in Public Service Settings

User-oriented Guidelines

https://trauma-informed-practice.eu/



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Trauma-Informed Practice for Workers in Public Service Settings (TIPS)

User-oriented Guidelines

PROJECT CONSORTIUM

The project consortium comprises a multidisciplinary team that includes legal, social, and medical research organizations, learning and media education specialists, and ICT communication experts.

Partners

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PTSS - Post-Traumatic Stress Symptoms
PTSD - Post-Traumatic Stress Disorder
TIP - Trauma-informed Practice
WHO - World Health Organisation

INTRODUCTION to the project

Central theme and objectives

The number of persons in Europe suffering from post–traumatic stress symptoms (hereinafter, PTSS) is likely to increase in the years to come. Thorough needs analyses tell us that especially in the public sector many professions are confronted in their work with clients who have PTSS. These professionals have their specific professional experience but little to no medical or psychological training on how to deal with persons who suffer from PTSS. Consequently, they frequently misjudge their clients. A 'trauma-informed approach' recognises the presence of trauma symptoms and acknowledges the role that trauma has played in an individual's life. It requires a change in paradigm from asking 'What's wrong with you?' to asking 'What has happened to you?'. Implementing trauma-informed practices help service professionals to recognise, understand and appropriately respond to the effects of trauma.

The Trauma-Informed Practice for Workers in Public Service Settings (TIPS) project received two-year funding (2021-2023) under the Erasmus+ programme of the European Union, and has a threefold objective: (1) to raise awareness about the occurrence of PTSS with professionals working in the public sector, (2) to equip them with skills for identifying PTSS among their clients, promoting their inclusion, and reducing barriers linked to discrimination, and (3) to improve the service and supporting work by professionals working in the public sector.

The TIPS project builds upon the successful Erasmus+ project 'Post-traumatic Integration – Low-level Psychosocial Support and Intervention for Refugees' (2017 – 2019)[1]. This project met with great interest and received the distinction as good practice project. The objective of this project was to raise the awareness about the occurrence of post-traumatic problems (including PTSD) among refugees and asylum seekers, the symptoms and possibilities for early low-level mental health interventions. The aim was to support the continuing professional development of frontline workers, primarily social, legal and educational professionals (such as teachers, trainers, mentors, etc.), especially because they have to deal with an increasing number of refuges/asylum seekers with various psychological, emotional, and behavioural difficulties. During the dissemination activities of this project, several partners and beneficiaries had been asking if the project could be extended to serve as support for various professionals who are in their work in contact with clients or people who suffer from post-traumatic stress symptoms but do not have a professional training.

Target groups

For this TIPS project, the target groups are all professionals (i.e. employees) providing services in the public (and also private) sector that may come into contact with clients (i.e. users of certain public sectors) with PTSS and that have little to no medical or psychiatric training. The aim is to provide useful information, awareness-raising material and exercises to train professionals of the public (and private) sector on trauma-informed practices in order to be able to provide support. Any supporter (i. e. professionals trained on trauma-informed practices) should be aware that they will likely be in contact with traumatised clients, and that they will very likely require further information in order to be able to help.

Even if the materials produced by this project could potentially be used by any professional working in the public (and private) sector, the consortium partners have identified more specific groups of professionals in order to facilitate the involvement of relevant stakeholders in the needs analysis, validation and dissemination phases of the project. Thus, we focused our attention mainly on the following professional sectors: justice (prison and police), local authorities (municipalities) and local community service providers (such as migration/refugee offices, labour offices, centers for people with special needs, residential homes for elderly, libraries, museums, theatres, education and health.

Project outputs

In order to meet its objectives, the project consortium partners jointly developed the following outputs, which are all grounded in scientific research and presented in accessible formats:

1) User-oriented Guidelines: the aim is to raise the awareness of professionals working in the public sector about the occurrence of PTSS among their clients. The Guidelines are an innovative answer to provide information and first-line management recommendations in order to enable the application of trauma-informed practices in the public (and private) sectors.

1 For more information about this project: https://posttraumatic-integration.eu/

2) Catalogue with a Case Studies Collection: the aim is to illustrate the most common work situations that can demonstrate how to react to clients who are suffering from PTSS. It contains comprehensive and easy-to-use recommendations and key actions for meeting the needs of clients with PTSS and dealing with their sometimes- challenging behaviour. The Catalogue offers a modular range of awareness-raising and demonstration materials.

3) Resource Pack: the aim is to provide interactive training and e-learning activities and quizzes related to the particular chapters of the Guidelines and Catalogue. It can be used as a self-learning course or in a structured form and adapted for specific requirements. The course has a modular structure and covers, among others, aspects of recognising the situation of clients, helping to solve acute problems and prevent problems in the longer run, and helping clients with PTSS to cope with their circumstances.

4) Interactive e-Platform: it supports the delivery of all materials of the project and provides online interactive tools such as blogs and social networking applications. With podcasts for the access-to-all contents it can be used as a virtual learning environment where users will be able to find the online training modules and participate in learning activities.

5) Mobile application: it adapts selected online materials from the e-Training Course, the Catalogue and the Guidelines in a pedagogically sound way and develops mobile apps for delivering these contents via smartphones and mobile devices.

All these products are available in English and the languages of the partnership, i.e. in Croatian, Dutch, French, German, Greek, Portuguese, Slovak, and Slovene.

Project consortium

The project consortium comprises a multidisciplinary team that includes criminological, social and medical research organisations, learning and media education specialists, and an ICT communication expert institution.

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1. BACKGROUND INFORMATION

"Evidence of the full impact of trauma has been emerging now for several decades, establishing beyond doubt that its effects can be wide-ranging, substantial, long-lasting, and costly. Resulting from harmful experiences such as violence, neglect, war and abuse, trauma has no boundaries with regard to age, gender, socio-economic status or ethnicity, and represents an almost universal experience across the countries of the world"[2]. Research on post-traumatic stress disorder (PTSD) after disasters conclude that more than two thirds of persons in the general population may experience a significant traumatic event at some point in their lives.

Several studies have explored the ways trauma can lead to mental health problems. These studies have all added to a growing evidence base demonstrating that large numbers of people in contact with public services have experienced traumatic events; that these experiences are causal in the development of mental distress and that there is a relationship between the severity, frequency and range of traumatic experiences, and the subsequent impact on mental health.

Professionals in various sectors are increasingly coming into contact with people who show trauma (symptoms) as a result of, inter alia, growing migration, COVID-19-related situations, and natural disasters. These professionals come from different backgrounds but often do not have a clinical background on how best to deal with trauma, and lack the resources to understand and promote mental health through early detection, referrals, and preventive and protective interventions that strengthen individual as well as community resilience. Trauma-informed work is, therefore, important because it allows professionals of the public service to identify signs of trauma so that there can be a first low-level intervention or a fitting response to the trauma as soon as possible. In the following chapters of these Guidelines detailed information is presented on what trauma-informed practices are, they key strategies and how to implement trauma-informed approaches within organisations. The concluding chapters of the Guidelines present the project awareness-raising and demonstration materials and interactive training and e-learning activities proposed.

It should be highlighted that the origins of trauma are manifold and can include any harmful experience in a person's life. Whether someone may develop post-traumatic symptoms depends also on personal coping capacities. In the following sections and chapters of these Guidelines, in-depth information will be given about what trauma is, what are post-traumatic stress symptoms (PTSS) and post-traumatic stress disorder (PTSD), and how it is possible to intervene. Great importance is given to enhancing self-awareness and self-perception, key components in trauma-informed practice.

In order to provide a glimpse on possible traumatic events, this introductory chapter will present main data and research findings about some of those events namely, (1) Covid 19 and its consequences, (2) conflict-related refugee flows and other migratory trajectories, and (3) natural disasters like earthquakes, fires, floods, and volcano eruptions. Moreover, by stressing that the material produced by this project could potentially be used by any professional working in the public (and private) sector, we are giving hereinafter a examples of the comprehension of particular professional sectors regarding post-traumatic reactions and symptoms.

Facts and figures concerning the impact of trauma (in Europe): some examples of potentially traumatic situations

In this section, we address the impact of trauma as the result of three types of situations, the Covid-19 pandemic, conflict-related refugee flows and other migratory trajectories, and natural disasters.

- Covid-19 pandemic

Trauma can affect any one of us at any time, but the Covid-19 pandemic has significantly increased and exacerbated both the risk and the impact of trauma. In the wake of the Covid-19 global pandemic, the impact of trauma has seldom been more evident, with many organisations increasingly seeing the need to address trauma as an essential component of their service delivery.

The Covid-19 pandemic increased global anxiety and several studies have reported its impact on people's mental health. Notably, high prevalence rates of post-traumatic stress disorder (PTSD) symptoms have been described in healthcare workers (26.9%), in individuals with Covid-19 (23.8%), and in the gen-

2 https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/pages/4/

eral population (19.3%)[3]. Studies discuss pandemic-related events that could be associated with the subsequent occurrence of PTSD symptoms. While the direct or indirect exposure to actual death or threatened death of those that contracted Covid-19 is clearly a potential traumatic event, studies discuss if the pandemic context as a whole or some specific pandemic-related consequences, such as quarantine measures and socio-economic repercussions, can be considered as traumatic.

Studies have revealed that the levels of distress and trauma symptoms are higher in individuals who have been in contact with Covid-19 patients (e.g., healthcare providers and family members of Covid-19 patients) due to the development of vicarious trauma[4]. However, the general public and vulnerable groups were not exempted from experiencing negative emotional reactions. This is because of numerous distressing features of the pandemic. In particular, fears frequently reported are relevant to the negative impact of the pandemic on the household finances of individuals, unavailability of health care, insufficient food supply, job loss/unavailability, and excessive fear of contracting the disease.

Moreover, physical distancing, primarily being locked down at home, caused several negative physical and psychological problems such as obesity, depression, and domestic violence. Large-scale studies show that being in self-isolation during Covid-19 was associated with a greater risk of depression, health anxiety, generalised anxiety disorder (GAD), financial worry, insomnia, acute stress, and loneliness. Moreover, Covid-19 fear, deficient coping, and vicarious trauma associated with frequent exposure to social media/news concerning the pandemic are identified mechanisms for increased Covid-19 psychopathology during the lockdown, especially in psychiatric/neurological patients, women, young age, and students. Imposed isolation, along with false or misleading information about Covid-19, may trigger a sense of perceived loss of control and jeopardize people's existential need to feel safe.

To address the generating stress caused by the pandemic throughout the world population, the World Health Organisation (WHO) developed mental health and psychological considerations. It also tailored messages targeting different population groups including the general population, healthcare workers, team leaders or managers in health facilities, care providers for children, older adults, people with underlying conditions and people in isolation.

As seen above, while the pandemic caused stress and anxiety to all population groups, several studies focus in particular on healthcare professionals - one of the most affected professional sectors - in order to understand and address their specific sources of anxiety. Indeed, within the medical community, the arrival of Covid-19 has added yet another acute level of stress in different forms such as moral injury, grief, and concerns for personal safety. Several other studies focus on addressing the trauma experienced by children and students as a result of the Covid-19 pandemic that triggered the security of their daily routine, critical to their well-being. Being instantly pulled away from their friends, teachers and schools interrupted the stability of their daily lives. For some students, it exacerbated existing trauma, for others, it created entirely new trauma through tragedies like a death in the family or food insecurity from job losses.

It is notable that most of these studies argue for the implementation of trauma-informed practices within different institutions to offer support to the widespread mental health issues caused by the Covid-19 pandemic.

- Conflict-related refugee flows and other migratory trajectories

One of the most important issues discussed at the national, as well as the European level, is the social integration of refugees and migrants into their host society[5]. In relation to this, and for the scope of our project, it is worth mentioning that relevant studies show that the circumstances and experiences of forced migration have profound effects on refugees'

3 Wathelet, M, D'Hondt, F, Bui, E, Vaiva, G, Fovet, T. (2021). Posttraumatic stress disorder in time of COVID-19: Trauma or not trauma, is that the question? Acta Psychiatr Scand. 2021 Sep;144(3):310-311. Doi: 10.1111/acps.13336. Epub 2021 Jun 23. PMID: 34107060; PMCID: PMC8212101.

4 Vicarious trauma is a process of change resulting from empathetic engagement with trauma survivors. Anyone who engages empathetically with survivors of traumatic incidents, torture, and material relating to their trauma, is potentially affected, including doctors and other health professionals. https://www.bma.org.uk/advice-and-support/your-wellbeing/vicarious-trauma/vicarious-trauma-signs-and-strategies-for-coping

5 In line with the previous Erasmus+ project 'Post-traumatic Integration' (see supra), we use the term 'refugee' in a generic sense, to imply a person fleeing from his/her local or national context for a variety of reasons that include persecution, war, violence, insecurity, poverty, natural disasters, etc.

health and integration into the host society. Thus, their levels of integration depend on a number of factors, including pre-migration experiences, the departure process and the post-arrival experiences and environment. Studies have shown that the presence of these potential traumatic experiences can cause post-traumatic symptoms that directly influence the refugee status decision-making process, PTSD, or other post-traumatic disorders.

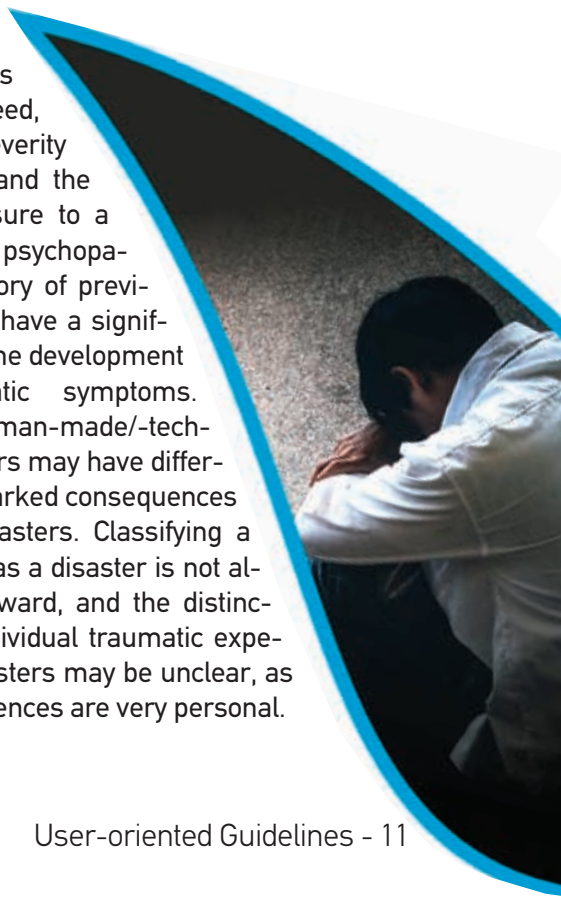
Although relevant studies have demonstrated that refugees present a high prevalence of trauma-related mental disorders, the rates of identified mental disorders vary substantially across these studies. This is due to three main factors: the characteristics and backgrounds of the refugee groups studied; the context in the host country (the poorer the host country the higher the prevalence of mental disorders); and the quality and sampling method of the studies. Thus, numbers and conclusions can vary significantly from one study to another. In a recent publication on refugees and social integration in Europe, the United Nations state that the most common disorders among refugees are PTSD and major depression, trauma, and loss. It, furthermore, reports that psychiatric surveys of refugees have indicated that 9% of adults were diagnosed with PTSD, 4% with generalised anxiety disorder and 5% with major depression, and 11% of children with PTSD. The World Health Organisation, for its part, states that the depression, as well as psychosis rates in refugees in Europe, are similar to those in the general population in Western countries.

Overall, it is important to highlight that the above-mentioned studies agree on two major points: refugees coming into Europe are much more likely than the general population in Western countries to have post-traumatic stress disorder (PTSD, 9% of refugees in general and 11% of children and adolescents); and the stress factors that refugees can be exposed to and that influence their mental health include: pre-migration factors (such as persecution, economic hardship), migration factors (physical danger, separation), and post-migration factors (detention, hostility, uncertainty). All three types of stress factors have different causes and consequences, but violence and exploitation are considered primary factors. Another interesting point to mark is that PTSD usually finds its origin in pre-migration trauma. The seriousness and nature of the disorder are heavily influenced by the experiences in the post-migration phase. More research is needed concerning the post-migration phase as stress factor.

- Natural disasters

Natural and human-made disasters (e.g., floods, transportation accidents) are traumatic events that are experienced by many people and may result in a wide range of mental and physical health consequences. Studies conducted in the aftermath of disasters during the past 40 years have shown that there is a substantial burden of PTSD among persons who experience a disaster. Recent research suggests that between 20% and 40% of survivors of disasters develop PTSD.

The range across studies is extremely broad and the results present a high variation due to differences in the characteristics/locations of disasters and methodological differences in the studies. On the one hand, the empirical evidence presented by some studies suggests that the prevalence of PTSD among direct victims of disasters is 30–40%, the prevalence among rescue workers is approximately 10–20%, and the prevalence in the general population is approximately 5–10%. On the other hand, a recent study conducted by the World Mental Health Association (WMH) tells us that disaster-related PTSD prevalence was 0.0–3.8% among adults (ages 18+) of the WMH respondents and was significantly related to high education, serious injury or death of someone close, forced displacement from home, and pre-existing vulnerabilities (prior childhood family adversities, other traumas, and mental disorders). This study also shows that nearly half of disaster-related PTSD occurred among the 5% of respondents with the highest predicted risk scores (on PTSD). Indeed, alongside the severity of the disaster and the degree of exposure to a disaster, prior psychopathology and history of previous trauma can have a significant impact on the development of post-traumatic symptoms. Interestingly, human-made/-technological disasters may have different and more marked consequences than natural disasters. Classifying a traumatic event as a disaster is not always straightforward, and the distinction between individual traumatic experiences and disasters may be unclear, as traumatic experiences are very personal.



- Specific vulnerabilities

Even if, as stated, trauma has no boundaries, the experience of trauma is known to be unequally distributed throughout society. Individuals are more likely to experience trauma because the circumstances in which they are born and live, their age, or their disability increases the likelihood of abuse and neglect. The definition of vulnerability, for example, is different for a child and an adult. Children are dependent on adults to keep them safe from harm. Vulnerability, therefore, increases when the adult's actions or inactions cause the child any harm. Studies on adverse childhood experiences show that childhood trauma is common and has long-lasting consequences in adulthood. The interesting toolkit The trauma-informed practice: a toolkit of the Scottish Government refers to a study that reports that: 30% of the sample of over 17,000 people reported substance use in their household; 27% reported physical abuse; 25% reported sexual abuse; 13% reported emotional abuse; 17% reported emotional neglect; 9% reported physical neglect; and 14% reported seeing their mother treated violently.

It is also important to note that research exploring the distribution of traumatic events based on gender, age, ethnic background and socio-economic status has also shown that traumatic events are more frequently experienced by people in low socio-economic groups and from minority ethnic communities. What is also relevant to consider is that vulnerability is complex and multifaceted and may be temporal, so specific populations may be at greater risk of poor health outcomes in times of crisis (see, for example, during the Covid-19 pandemic). Those affected may stop achieving in life and feel unable to engage or access services once they experience the impact of the traumatic event.

Examples of some professional sectors that may come into contact with clients with post-traumatic symptoms

Hereinafter, we provide the main findings of the mapping exercises done by the project partners in their respective countries through a variety of methods, including literature review, focus groups, interviews, and questionnaires. Each partner focused on specific professional sectors, based on their expertise, to gather information about the awareness and understanding of professionals of post–traumatic reactions and symptoms. As the project consortium did not carry out a wide and in-depth research in the field, the following results are only meant to offer some indications.

- Justice sector (police and prison)

The research done in Belgium[6] focused on trauma-informed work of professionals in the criminal justice system, specifically in the police and in detention centers. It revealed that perceptions of police towards traumatised victims can have an impact on secondary victimisation that could be caused by misunderstandings around trauma and typical behavioural patterns of the victims. One example is that victims often show a lack of emotions or a fragmented memory of the experience. This can be qualified (by the police) as a sign that the statement is not to be believed or is not reliable. Police officers frequently have a lack of knowledge around symptoms of trauma, but the need to learn around this topic is however something they are very eager to learn about. The reduction of the lack of awareness and knowledge about trauma can have positive impact on attitudes and perceptions and, in addition, it could also have an impact on agents' self-confidence, which may lead to increased support for traumatised individuals.

A recent study argues that trauma-informed training should be guided[7]. What is needed, to begin with, is a general education about psychological symptoms before moving on to more specific and detailed skills such as interviewing traumatised children. The researchers argue for facilitating the acceptance of trauma-informed training among police officers to work with "self-selectable education units" so that participants can choose courses themselves depending on their current position and transient knowledge.

Furthermore, the introduction of trauma-informed work would help correctional staff to minimize triggers and critical incidents, stabilize inmates and de-escalate situations. Thus, it would help staff to deal with trauma-related behaviors and symptoms,

6 This is a summary of the research done by KU Leuven criminology student Alessandra Possemiers based on a literature review on trauma-informed work (2022). Naar een trauma-informed benadering in het strafrechtsysteem (Towards a trauma-informed approach in the criminal justice system). KU Leuven: Faculty of Law and Criminology.

7 Lorey, K., & Fegert J. M. (2022). Incorporating Mental Health Literacy and Trauma Informed Law Enforcement: A Participative Survey on Police Officers' Attitudes and Knowledge Concerning Mental Disorders, Traumatization, and Trauma Sensitivity. Psychological Trauma, 14(2), 218-228.

which are perceived as difficult by them. It could enhance the understanding of the origin of the delinquent behaviour and could help in the development of intervention strategies. Professionals become traumatised themselves as a result of interacting with traumatised individuals, even though they did not experience the traumatizing event.

Research conclude that, although trauma-informed working varies from context to context in the criminal justice system, trauma-informed principles such as empathy, communication, building trust, and compassion should be central to the implementation of trauma-informed work In addition, regardless of the context, emphasis should also be placed on the well-being of the personnel who come into contact with traumatised individuals. More specifically, within the police, emphasis should be placed on the application of trauma-informed principles when interviewing potentially traumatised individuals. Within detention, on the other hand, the implementation of trauma-informed principles could be a start toward greater expansion of trauma-informed work in prisons. Regarding trauma-informed training in both police and detention, the bulk of the training should revolve around trauma and its recognition. Here, trauma-informed principles such as empathy, communication, trust and compassion are also central.

- Public administration sector

The needs assessment in Slovakia was conducted with the public administration sector[8], in particular with different institutions that come into contact with refugees. It made clear that the understanding of PTSD/PTSS was expressed correctly. In their professional activities they did not encounter persons manifesting PTSD. Their opinion is that the response to a person with trauma should include the provision of a quiet place, supporting basic needs and psychological intervention. It is important to stress that the public service workers are not supposed to offer professional intervention (they are not psychologists), but only to respond empathically to the client's needs. These professionals would welcome as much information as possible (including examples) to differentiate symptoms and how to use an empathic approach, which would enable them to better choose their approach and interaction with the client. Their perception of the impact of their response to a client with PTSD is that the client would feel more comfortable and understood.

- Health sector

From the needs assessment done in Croatia, it appeared that awareness levels of post-traumatic reactions are rather low among health professionals. There is a need for a better understanding of post-traumatic reactions in general. This is especially true for reactions which are oriented inwards, unlike those recognisable on the behavioural level such as low frustration thresholds, anger issues, etc. There is an existing stereotype of persons with PTSD as angry and aggressive people. More knowledge should be spread on differences between acute and chronic reactions, other associated mental health issues (e.g., substance use), as well as the type of traumatic background. Victims of family and/or sexual abuse are especially at risk of not being recognised, and consequently put through re-traumatisation due to the lack of skills among public services employees.

Health professionals often do not know how to identify PTSS and how to promote inclusion and reduce barriers linked to discrimination. There are at least two groups of skills needed, one related to the recipients of the service, and those related to the health workers themselves. There is a significant need for training and educational materials that deal with providing information in a trauma-informed way, especially in situations of acute traumatisation and/or giving out 'bad' news. Results suggest that health workers feel they lack skills in providing unspecific help on the level of psychological first aid and how to contact or reach out to a traumatised individual. Participants in health services expressed their need for training in skills related to self-care which include setting boundaries, how to deal with strong emotions, how to deal personal post-traumatic reactions, how to prevent emotional burnout, keeping a good work-private life balance, and others. Also, there is a need for training in de-escalation techniques and even in basic communication skills.

Through a focus group and a survey, health service workers expressed an interest in advancing their knowledge and skills and recognise the need for trauma-informed service for the benefit of all parties involved. There is a clear need for educational materials on the topic, in the form of guidelines as well as trainings.

8 More than forty actors in the public administration sector were contacted, namely municipal authorities dealing with the housing issue of socially excluded communities or refugees, voluntary organisations, organisations in direct contact with refugees (not psychologists), schools. They were asked to fill in the responses in full sentences into online form - Questionnaire.

- Educational sector and social work

In Portugal, the needs assessment was carried out among professionals in the field of education and social work, with the aim of investigating their knowledge about trauma and signs and symptoms of post-traumatic stress (PTSS). Most of the participants were teachers from the three levels of education (i.e., primary, secondary, and tertiary). The results revealed that these professionals have limited knowledge about the conditions of PTSS, which may prevent them from identifying people in a situation of psychological crisis. They also reveal a lack of knowledge about how to act in these circumstances. Although most of these professionals have a degree, they have no formal education or training in the areas of psychology, mental health or psychological aspects and therefore have no formal knowledge about PTSD and PTSS.

Most feel that they have adequate organisational skills for their daily work, although they feel that the development of communication skills, as well as understanding the culture from which clients come would be very useful and important for their work. Many of these professionals have had periods in their work when they felt very tired both physically and emotionally, as well as some have experienced conflict situations in which they felt afraid and did not know how to resolve these situations. Most of these professionals agree or strongly agree that a manual/guidelines for recognising post-traumatic reactions and symptoms and the impact of trauma on behaviour would be important. They also consider that it would be important to develop interpersonal skills and communication strategies to better perform their professional activity in these situations. Self-care strategies would also be useful.

The results showed that the needs in this field are real and actual: professionals feel the need for this knowledge, especially after the pandemic and with the increase of immigrant students. These students, particularly in higher education, are now more introverted and have fewer intergroup skills, which makes it difficult to establish a relationship and hampers their integration. Teachers reveal that they do not feel prepared to deal with new situations, such as, for example, a student crying because his father has stayed in the war context. Therefore, they feel the need for training to be able to better understand other cultures, to know how to identify PTSS and to act in response to these manifestations, namely in terms of communication skills and other social skills.

2. POST-TRAUMATIC STRESS SYMPTOMS (PTSS) AND POST-TRAUMATIC STRESS DISORDER (PTSD)

What is trauma?

In general, traumatic events are those that involve death or threatened death, actual or threatened serious injury, or threatened sexual violation. Some of them have a greater risk of developing into more serious and long-term mental health consequences. For example, interpersonal trauma (e.g., sexual assault, physical assault) contain the greatest level of risk, as well as exposure to multiple lifetime traumatic events (a cumulative effect). Exposure to a traumatic event may be direct or indirect, i.e. witnessing the trauma or learning that a relative or close friend was exposed to a trauma. Differences in trauma characteristics, along with differences in personal characteristics, may affect the risk of developing post-traumatic reactions, symptoms, and disorders.

Most of us will experience at least one traumatic event in our lifetime. Not everyone who experiences it will develop trauma. Some people will develop symptoms that resolve shortly after the event, sometimes after a few weeks, while others will have more long-term effects.

- Trauma is an unexpected sudden experience that exceeds usual human experiences

Psychological trauma is a response to an event that a person finds highly stressful. It is the unique subjective experience of a potentially traumatic event or enduring conditions. Individuals perceive the event as a threat to their life, bodily integrity, or that of a caregiver

or family, while the individuals' ability to integrate their emotional experience is overwhelmed. Most people are exposed to a single stressful or dangerous event that are unexpected and come out of the blue. They can be referred to as shock or 'acute trauma'. Repetitive or 'chronic trauma' results from repeated exposure over a period and is often part of an interpersonal relationship where someone might feel trapped emotionally or physically. 'Complex trauma' describes trauma which may have been experienced as part of early stages of development or/and results from exposure to multiple traumatic events. 'Collective' or 'transgenerational' trauma is characterised by psychological or emotional difficulties that can affect different communities, cultural groups, and generations (e.g., racism, slavery, forcible removal from a family or community, war). Family members, mental health professionals, and others who care for those who have experienced a traumatic event are at risk of 'vicarious' or 'secondary' trauma. This type of trauma can occur when someone speaks to someone who has experienced a trauma or witnessed a trauma first-hand. The person listening can experience secondary trauma and experience symptoms experienced by the person explaining the trauma. A traumatised person can feel a wide range of post-traumatic symptoms both immediately after the event and in the long term.

Which post-traumatic symptoms and reactions may occur during and after the exposure to a traumatic event?

- In most people, an immediate stress reaction is a normal reaction to an abnormal situation

When somebody experiences a traumatic event, it is common to have a reaction. Such stress reactions are normal and should not be perceived as weakness. For most of us, those symptoms will then go away on their own. This is known as 'natural recovery' or 'resilience'. Some people never experience any major problems. This is known as 'resistance'. Other people experience problems that do not go away on their own. 'Post-traumatic stress disorder' (PTSD) is one potential outcome when this happens. The post-traumatic symptoms could be present at the level of emotions, thoughts, body, and behaviour. It is not unusual for traumatised people to experience symptoms at different levels at the same time. There is a need for a better understanding of post-traumatic reactions which are oriented inwards and thus experienced at the level of emotions and thoughts. Thoughts and emotions are inside us, and we do not have to act on our thoughts and emotions. Most of the post-traumatic symptoms and reactions are highly subjective, personal, and not recognisable at first sight, particularly in non-trauma-informed settings. Traumatised people with that type of symptoms are in danger of being re-traumatised in those settings.

Emotions are subjective experiences that occur as a response to trauma exposure and are normally quite short-lived, but intense. Mixed emotions are more common than pure forms of each emotion. The most common emotions in response to trauma are fear, anxiety, extreme nervousness, irritability, anger, sadness, guilt, and feeling numb (shut down emotions). However, individuals may encounter difficulty in identifying any of these feelings for various reasons.

Emotional reactions to trauma can vary greatly and are significantly influenced by the individual's memory and experience and are also closely linked to values and core life assumptions (cognitive reactions, thoughts). In other words, a person's emotional experience typically results from a subjective interpretation of an event rather than from the event itself. Furthermore, traumatic experiences can affect and alter a person's thoughts. Trauma can lead to self-defeating ideas, beliefs of personal incompetence, damage or being different, viewing others and the world as unsafe and unpredictable, and future as hopeless or foreshortened.

While experiencing an emotion, we may have body reactions. When facing a threat, our body is prepared for 'fight-or-flight' reactions. These responses automatically prepare our body to flee from danger or face the threat head-on. Usual immediate body reactions are racing heartbeat, or rapid breathing, lump in your throat, need to go to the toilet, sweating palms, uncontrollable shaking. Possible long-term body reactions are nausea and/or gastrointestinal distress, appetite changes, sleep disturbances, increased focus on body aches and pains - somatizations, fatigue, and long-term health effects.

Our behaviour is what we do and how we act. This could include physical things, like jumping or running, verbal behaviour, like yelling, saying things we regret later, or more complicated behaviours. Typical post-traumatic reactions at the level of behaviour are restlessness, crying, withdrawal, not speaking to others, outbursts of anger or aggressiveness, staring into space, being constantly on guard, avoidance and increased use of alcohol or

drugs. Behaviours are different from thoughts and emotions because they are about what we do in the world and are obvious to everybody. Hence, an extreme minority of traumatised people who express open aggressive behaviours contribute to an existing stereotype of PTSD affected people as angry and aggressive.

What could be the long-term mental health consequences of traumatic exposure?

- The most common effects of stress are strength, growth, and resilience

Traumatic experiences can enhance resilience and enforce positive change through adversity-activated development. Many of those who have survived extremely traumatic events have found meaning in their suffering. Post-traumatic growth is a process that is stimulated by the experience of post-traumatic symptoms followed by processing it at a deeper level and ultimately being able to grow from it.

Some traumatised people experience post-traumatic symptoms that do not go away on their own. Post-traumatic stress disorder (PTSD) is one potential outcome when this happens. Unlike other mental health disorders, PTSD has an external cause, namely trauma. Those who have been exposed to multiple traumatic events are in danger of experiencing symptoms of complex PTSD. Unfortunately, other psychiatric disorders in combination with PTSD are more the rule than the exception. Some of them try to lessen suffering using different substances (so called 'self-treatment') ending with substance use disorders. Depression is also one of the most common concurrent conditions. People with diseases prone to worsen in exposure to traumatic stress (psychosomatic disorders) such as peptic ulcer, asthma, or skin diseases could experience more difficulties in the aftermath of the traumatic event. Patients with pre-existing mental health conditions are vulnerable to such deterioration.

How to approach/intervene?

When you encounter a traumatised person in a public service setting, it is of the utmost importance to recognise and differentiate two types of situations: on the one hand, individuals requiring immediate professional care, and on the other hand, individuals who need psychosocial support, a trauma-informed approach and/or psychological first aid (low-level interventions). In other words, the triage must be made. Everybody could be a person in need of professional help, but it is advisable to be aware of particularly vulnerable groups who are more prone to serious mental health difficulties after a traumatic experience: children – including adolescents – especially those separated from their caregivers, people with severe mental disorders, people with health conditions or physical and mental disabilities, pregnant women, people at risk of discrimination or violence, economically disadvantaged minorities, and individuals with language barriers.

Those who need immediate professional help are people who express: sustained inability to move or freezing; loss of memories, such as facts, information and experiences; those who look like they are detached from reality or themselves (dissociation, depersonalisation, de-realization); people who are in a state of extreme arousal (e.g., panic attacks, increased and/or irregular heartbeat); those who have dysfunctional guilt reactions (survivor guilt, responsibility guilt); persons who are giving up (e.g., helplessness, hopelessness); those with self-destructive thoughts (e.g., suicidal or thoughts of killing someone else); or those who demonstrate disorganised, violent, aggressive (autoaggressive or/and heteroaggressive) behaviour that stems from mental disturbances; or people with functional impairment (e.g. social, occupational, in caretaking responsibilities, etc.). In all such cases, it is important to refer the traumatised person to professional help.

What is trauma informed practice in public services?

A trauma-informed approach shifts the focus from "What's wrong with you?" to "What happened to you?" Key assumptions in the trauma-informed approach are:

- Awareness of trauma and the widespread impact of trauma
- Recognition of the signs and symptoms of trauma
- Active avoidance of re-traumatisation
- Ability to make a skillful triage of those in need of professional help
- Integration of knowledge about trauma into practices (emotions and stress management, psychosocial support, empathy, and recovery approach)
- Awareness of the possibility of compassion stress, secondary traumatic stress, and burnout in helpers

3. THE BASICS OF POST-TRAUMATIC STRESS DISORDER, SIGNS AND SYMPTOMS

What is PTSD?

Most people who went through traumatic events may have temporary difficulty adjusting and coping, but with time and good self-care, they usually get better.

If the symptoms get worse, last for months or even years, and interfere with day-to-day functioning, it could constitute a post-traumatic stress disorder (PTSD). PTSD is a mental health condition that is triggered by a traumatic event. PTSD develops when psychological balance or 'homeostasis', after a traumatic event is not re-established, and the organism stays in a state of 'allostasis' or a sort of 'new normality' that reflects the underlying neurophysiological processes. This is a significant health issue described as a chronic condition related to social and work difficulties, as well as to numerous other health issues. Unlike other mental health disorders, PTSD has an external cause, and the trauma could be either directly experienced or witnessed. PTSD can develop at any point in the life span but depending on the onset and duration of symptoms it can be recognised as acute (less than three months), chronic (three months or longer), or with delayed onset. In the general population the prevalence of PTSD is around 10%, but in populations that were exposed to war and/or combat trauma, or in those exposed to sexual trauma, it can be as high as 30%. In most cases PTSD symptoms spontaneously disappear or go into remission five to seven years after the trauma, and in most cases, they reappear around the time of the anniversary of the event.

What are the symptoms of PTSD?

Post-traumatic stress disorder symptoms may start within one month of a traumatic event, but sometimes symptoms may appear years after the event. PTSD symptoms are grouped into a triad of symptoms:

- **Re-experiencing the traumatic event:** intrusive images, thoughts or perceptions; distressing dreams or nightmares about the traumatic event, acting or feeling as if the event is happening again (flashbacks); psychological and physiological reactivity to internal or external cues resembling the event, like smell, colour or sound.
- **Avoidance:** efforts to avoid thoughts, feelings or conversations about trauma; efforts to avoid activities, places, or people that remind of trauma; inability to recall important aspects of trauma; diminished interest in significant activities, restricted range of affect, sense of foreshortened future.
- **Hyperarousal:** sleep difficulties; irritability and outbursts of anger; difficulty concentrating; being easily startled or frightened, always being on the guard for danger; one may develop self-destructive behaviour, such as drinking too much or driving too fast.

PTSD symptoms can vary in intensity over time. Persons may have more PTSD symptoms when they are stressed in general, or when they come across reminders of what they went through. Often the anniversary of the event intensifies the PTSD symptoms.

What are the signs of PTSD?

Symptoms are a very personal experience and we can learn about them if the person tells us. What we can observe are signs of an illness or disorder.

People suffering from PTSD may have difficulties in communication, being either withdrawn, not interested in important issues, or avoiding any task that needs communication. On the other hand they may be irritable, inpatient, demanding and prone to accuse for lack of respect. They may quickly change their mood or react unexpectedly on some traumatic reminder which will activate the physiological response of fightorflight like changes in heart rate and affect. The unpleasantness of feelings may lead to the effort not to think about trauma by using alcohol or other substances.

Complex PTSD

While PTSD is generally related to a single traumatic event, 'complex PTSD', on the other hand, is related to a series of traumatic events over time or one prolonged event. The symptoms of complex PTSD can be similar but more enduring and extreme than those of PTSD.

Intense and prolonged exposure to traumatic events, combined with other risk factors such as age, pre-trauma mental health issues, early life trauma, and lack of social support, can lead to significant changes in personality development. One is more likely to develop complex PTSD if the trauma

is experienced at an early age, the trauma lasted for a long time, has experienced multiple traumas or was harmed by someone close.

This long-term effect of trauma is called 'complex PTSD'. In addition to PTSD symptoms, the complex form emphasizes changes at the personality level through alterations in regulation of affect and impulses, self-perception, relations with others and systems of meaning.

What are the symptoms of Complex PTSD?

In addition to symptoms of PTSD, complex PTSD displays the following:

- emotional, affective dysregulation that comprises increased emotional reactivity, outbursts of anger, tendency towards prolonged dissociative states, emotional numbing with lack of capacity for positive emotions (hyperreactivity or hypo reactivity),
- self disturbances (negative self-concept, shame or guilt feeling),
- difficulties in interpersonal relations with diminished feeling of closeness, avoidance of relation or temporarily intensive relations that are short lasting.

Symptoms of negative changes in thinking and mood may include negative thoughts about oneself, other people or the world, hopelessness about the future, memory problems, including not remembering important aspects of the traumatic event, difficulty maintaining close relationships, feeling detached from family and friends, difficulty experiencing positive emotions, feeling emotionally numb and having suicidal thoughts.

One of the features of complex PTSD are so called 'cognitive distortions'. Those who suffer from complex PTSD have persistent negative beliefs about themselves (i.e. "I am not good") and the world ("I cannot trust anyone"), and an exaggerated blame of self or others for causing the trauma ("I deserved this to happen to me"). They may be preoccupied with thoughts on the perpetrator or abuser and thoughts on possible revenge, thus maintaining the victim position.

Persons with complex PTSD may be particularly likely to experience a sort of 'emotional flashback', in which they have intense feelings that were originally felt during the trauma, such as fear, shame, sadness or despair. They might react to events in the present as if they are causing these feelings, without realising that they are having a flashback. All symptoms can vary over time or vary from person to person.

What are signs of complex PTSD?

People with complex PTSD are extremely sensitive toward the way others treat them. Any behaviour that they may feel as irrespective could exaggerate their feeling of shame, guilt or worthlessness. This may cause withdrawal, avoiding or irritable reaction. They are prone to give up from everything that is socially demanding. They will have difficulties maintaining communication and may feel like everybody is against them.

Comparison of PTSD and Complex PTSD symptoms:

PTSD	Complex PTSD
Reexperience	Reexperience
Avoidance of trauma reminders	Avoidance of trauma reminders
Threat feeling	Threat feeling
	Affective dysregulation
	Negative self-concept
	Interpersonal difficulties
Less functional damage	Higher functional damage

In addition to the described symptoms, almost 80% of individuals with PTSD and complex PTSD have at least one more mental health disorder, most commonly depression and substance abuse. Both, PTSD and complex PTSD are serious conditions that require professional attention.

Common myths about PTSD

There are many misconceptions and myths about post-traumatic stress disorder (PTSD). Although many people will experience some type of trauma in their life, not everyone goes on to develop PTSD. These are some of the common myths and facts related to PTSD:

Myth 1: People suffer symptoms of PTSD right after a trauma

Symptoms often show up in the first few months after a traumatic event, but sometimes symptoms do not appear until years after. It is different for everyone who develops PTSD.

Myth 2: People with PTSD are dangerous

The majority of people with PTSD does not show violent behaviour. PTSD is associated with an increased risk of violence, but most people with it have never acted violently. Research shows that when risk factors correlated with PTSD are taken into account, the association between PTSD and violent behaviour drops significantly.

Myth 3: PTSD can only affect adults

Another myth that surrounds PTSD is that children and teens cannot develop this mental health disorder because they have resilience and the ability to overcome serious hardship. However, children even younger than six can have symptoms of PTSD.

Myth 4: Symptoms of PTSD go away as a person heals from trauma

Symptoms of PTSD can come and go, and can vary in intensity over time. Reminders of the trauma, even many years later, can cause long-dormant symptoms to reappear. It is called re-experiencing a trauma, and it is common in people with PTSD.

Myth 5: Everyone reacts to trauma the same way

While people go through similar traumatic experiences, this does not mean it will affect them exactly the same way. Your personal mental health and life experiences are not identical to anyone else's, so your reaction to trauma, and your recovery will not be identical to anyone else either.

Myth 6: Without physical injury PTSD does not require medical attention

Even without a physical wound, PTSD is a sign of an injury. The daily lives of many people with PTSD are interrupted by symptoms such as panic attacks and sleeplessness.

Myth 7: PTSD only affects weak people

It is not a question of strength, or of emotional stamina. There are a number of factors that determine whether a person who has gone through a trauma develops PTSD. The risk of getting PTSD depends, in part, on a combination of risk factors and resilience factors.

Myth 8: PTSD is all in a person's head

Traumatic events can change how the brain functions. PTSD leads to measurable changes in the brain and body after a person has been exposed to a trauma.

Myth 9: PTSD is not treatable

It is actually quite treatable, even if it is not completely curable in everyone. PTSD is frequently treated with drugs combined with psychotherapy. The most frequently used are counselling, exposure therapy, and behavioural therapy and EMDR. Nutrition is a key component in any healing regimen and there is also evidence that meditation can help people with PTSD.

Post Traumatic Integration Awareness Raising Guidelines p. 19: https://onlinematerial.post-traumatic-integration.eu/guidelines%2FPTI%20Guidelines%20EN.pdf

4. IMPLEMENTING TRAUMA-INFORMED PRACTICES IN PUBLIC SERVICES

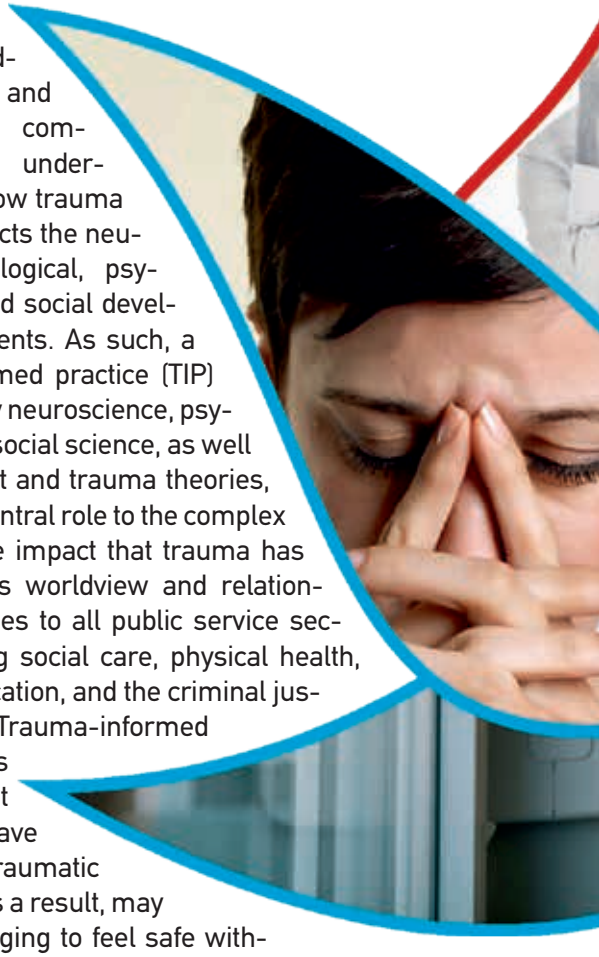
It is especially important to emphasise from the outset that the recognition and empowerment of clients, users of certain public services, are not intended and cannot be a substitute for the professional help by experts, counsellors and therapists. The strategies described in this section raise awareness and strengthen the knowledge and skills of professionals in public services when working with clients, but do not give them accreditation for counselling and therapy. This certainly requires an organised community network of services that complement and build on each other. Therefore, it is important to know and distinguish between individual types of assistance, as well as to know the limits of one's own professional competence. The section mainly focuses on insight and gaining additional knowledge in the field of low-level psychosocial support, which is increasingly needed in some public services.

Trauma-informed organisation

Trauma, which is the result of harmful experiences such as violence, neglect, war, and abuse, transcends age, gender, socioeconomic status, and ethnicity, and is a nearly global phenomenon. Research examining the distribution of traumatic events based on gender, age, ethnic background, and socioeconomic status has revealed that people from low socioeconomic groups and minority ethnic communities are more likely to experience traumatic events. In the wake of the global COVID-19 pandemic and the war in Europe, the effects of trauma have never been more apparent, with an increasing number of organisations viewing trauma as an essential component of service delivery. However, addressing trauma requires a multifaceted, multi-agency approach that includes awareness-raising and education, working upstream, and trauma-specific assessment and treatment. All of these efforts must be conducted within a trauma-informed framework, based on a solid understanding of trauma and its far-reaching effects, in order to have the greatest possible impact.

The path to becoming a 'trauma-informed organisation' will require organisations to abandon their traditional service delivery models and re-evaluate their entire organisational practices and policies through a trauma-focused lens. As part of this re-conceptualisation of services, organisations will be required to reframe complex behaviours as responses to trauma-related triggers and to prioritise the development of trusting, mutual relationships. A vast body of research on trauma-informed practice identifies the path forward for new models of service delivery: "from fear to safety, from control to empowerment, and from power abuse to accountability and transparency"[9]. The development of a working concept of trauma and a shared understanding of the steps organisations can take on their journey towards trauma-informed practice have been fundamental to this direction.

What does Trauma-informed Practice (TIP) mean?



It is a model based on and guided by a comprehensive understanding of how trauma exposure affects the neurological, biological, psychological, and social development of clients. As such, a trauma-informed practice (TIP) is informed by neuroscience, psychology, and social science, as well as attachment and trauma theories, and gives a central role to the complex and pervasive impact that trauma has on a person's worldview and relationships. It applies to all public service sectors, including social care, physical health, housing, education, and the criminal justice system. Trauma-informed organisations assume that individuals have endured traumatic events and, as a result, may find it challenging to feel safe within services and to develop trusting relationships with service providers. As a result, services are structured, organised, and delivered so as to foster safety and trust and prevent re-traumatisation. Consequently, trauma-informed services can be distinguished from trauma-specific services, which

9 Concetta, P. (2018). Survivors voices, personal communication, in Sweeney, A & Taggart, D. (2018). (Mis)understanding trauma-informed approaches in mental health. Journal of Mental Health, 27(5), 383-87.

are designed to treat the effects of trauma using specific therapies and other methods.

Why is it important to understand trauma and be trauma-informed? A literature review demonstrates that trauma-informed practice is effective and can benefit both trauma survivors and staff members. Trauma-informed services can offer trauma survivors empowerment, and non-traumatising support. Moreover, these services can help bridge the gap between service recipients and service providers. Thus, the provision of staff training, supervision, and support is of the utmost importance and becomes as relevant to staff as it is to the clients. In fact, organisations that do not encourage their employees to take care of themselves risk exposing them to secondary traumatic stress, vicarious trauma, and burnout, all of which will hinder their ability to provide high-quality service.

Key principles of a trauma-informed approach

Adapted from Fallot and Harris (2006), the following is a list of TIP's guiding principles:

1. Safety

An organisation makes efforts to ensure the physical and emotional safety of clients and employees. This includes freedom from reasonable threat or harm and efforts to prevent further re-traumatisation.

It is essential to ensure the physical and emotional safety of all parties, including yourself. Aspects of physical safety may include selecting a location that ensures the affected individuals' privacy and confidentiality. If they are agitated and highly stressed, they may become oblivious to their surroundings and begin conversing while walking alongside heavy traffic or a busy parking lot; in this case, you will need to gently steer them away from any physical danger. However, threats to their emotional safety, such as experiencing an intensely negative emotional reaction during the conversation (being 'triggered'), may be more prevalent. Continue monitoring the individual for signs of stress and, if necessary, assist them in calming down, such as by taking short breaks or encouraging them to breathe slowly and deeply. Ensure that your nonverbal communication demonstrates that you are supportive, attentive, and focused, such as by maintaining good eye contact and using appropriate facial expressions such as nodding and smiling at the appropriate time. If the person is still visibly distressed after the conversation has concluded, do not leave him/her alone until they have sufficiently calmed down.

2. Trustworthiness

The policies and procedures of an organisation are transparent with the intention of fostering trust among staff, clients, and the larger community.

Interpersonal trauma is caused by upsetting, harmful, or life-threatening experiences caused by others, such as family and domestic violence, severe bullying, and sexual harassment. One of its characteristics is a breach of trust, which frequently results in betrayal trauma (psychological damage caused by betrayal in a relationship which destroys trust and a sense of security). Therefore, traumatised individuals frequently find it difficult to trust others, and it may take some time for them to trust you. If you sense a person's suspicion or extreme caution in their interaction with you, do not take it personally or respond with impatience or annoyance. You may be able to gain trust by remaining attentive to the needs and nonverbal communication of the person, taking a gentle approach and not bringing an "agenda" to the conversation (such as pushing someone towards a particular action or insisting on expectations), giving your undivided attention in your interactions, and refraining from passing judgment or interrupting the person.

3. Choice

Clients and employees have meaningful input and choice in the organisation's and its services' decision-making process.

Because trauma removes a person's ability to make decisions, it frequently results in feelings of helplessness and loss of control. You can help a distressed client, peer, or staff member regain a sense of control by giving them as many options and choices as possible, such as regarding the time and location of your conversation, the way it is held and developed, the level of detail they would like to discuss, when they would like to end the conversation or take a short break, and – where possible and appropriate – what they would like you to do with the information they provide.

4. Collaboration

The organisation acknowledges the importance of staff and client experience in overcoming obstacles and enhancing the entire system. This is frequently implemented through the formal or informal use of peer support and mutual self-help.

This principle describes the distinction between doing something with someone versus doing something to them. Remember that you are there to provide support, not to take complete control of the situation, as this would only exacerbate the feelings of helplessness and lack of options that a severely distressed or traumatised individual is likely to already be experiencing. Naturally, you should assist if the person requests it (as long as you feel comfortable and it is appropriate to do so), such as by calling a family member or friend for support or speaking to a manager or health professional on behalf of the person, but never without his/her permission.

5. Empowerment

Individual and organisational efforts are made by the organisation to share power and give clients and employees a strong voice in decision-making.

Restoring a sense of personal power is crucial to a person's recovery from interpersonal trauma, which frequently results from power imbalances in relationships. You can help by assisting the individual in restoring self-esteem (for instance, by emphasizing strengths and validating thoughts and emotions), maintaining respectful and inclusive interactions, and treating the individual as an equal partner.

Interacting with traumatised, bereaved, or extremely distressed individuals can be emotionally draining and confronting; therefore, it is essential to take also care of yourself and ensure your psychological safety and well-being. Remember that while you can offer assistance, you are not responsible for the actions and decisions of others. If you are unsure of what to do, if you feel overwhelmed by the other person's story, or if you would like another viewpoint, do not hesitate to reach out.

Using the five principles of trauma-informed communication in the workplace is beneficial. They are essential in interactions with distressed people, whether you initiate the conversation (for example, because you want to check in with and support a colleague you suspect is mentally ill or has experienced trauma) or respond to a client or team member relating a traumatic experience. It is helpful to consider these principles as the hallmarks of respectful communication in any situation, not just during a crisis. Positive and psychologically safe workplace cultures are preconditions for the development of positive personal and professional relationships.

Source: Chart by the Institute on Trauma and Trauma-Informed Care (2015). Retrieved from the website of the Buffalo Center for Social Research (here).

Triggering events

The term 'triggered' refers to the experience of having an emotional response to a disturbing topic (such as violence) in the media or in a social setting. There is a distinction, however, between being triggered and being uncomfortable.

For persons with a history of trauma, being exposed to anything that reminds them of a traumatic event can induce re-traumatisation, or the feeling of re-living the trauma. Some people are better able to handle stressful situations than others; consider the impact such situations may have on those with mental illness.

Re-traumatisation refers to any situation or environment that resembles a person's trauma, either literally or symbolically, and elicits distressing emotions and behaviours associated with the initial trauma. Re-traumatisation is possible in all systems and at all levels of care, including individuals, staff, and system/organisation.

Frequently, re-traumatisation is unintentional. Some 'obvious' practices, such as the use of restraints or isolation, may be re-traumatising; however, less obvious practices or situations involving specific smells, sounds, or types of interactions may cause individuals to experience re-traumatisation.

Re-traumatisation is a major concern, as individuals who have experienced multiple traumas tend to exhibit more severe trauma-related symptoms than those who have only experienced a single trauma. Multiple trauma experiences are frequently associated with a decreased willingness to engage in treatment. Re-traumatisation may also occur when interacting with people who have experienced historical, intergenerational, or cultural trauma.

Types of Triggers

Triggers vary greatly between individuals and can be internal or external. The following are events that could be considered triggers.

Internal Triggers

An internal trigger originates from within the individual. It might be a recollection, a physical sensation, or an emotion, such as:

- Anger
- Anxiety
- Feeling vulnerable, abandoned, or out of control
- Loneliness
- Muscle strain
- Recollections of a traumatic event
- Pain
- Sadness
- External Triggers

External Triggers

External triggers originate from the individual's surroundings. They may be a person, a location, or a particular circumstance. What may be an everyday occurrence or minor annoyance for some may be a trigger for someone with post-traumatic stress syndrome (PTSD).

For instance, a traumatised individual may be triggered by:

- A film, television program, or news article that recalls the experience
- A participant in the experience
- A disagreement with a co-worker, superior, friend, partner
- A particular time of day
- Certain sounds that evoke memories of the event
- Alterations to or the end of a relationship
- Important dates including holidays and anniversaries
- Visiting a specific location that brings back memories of the event
- Aromas connected to the experience, such as smoke

The brain may interpret past traumatic events as current when triggered. This causes the body to experience similar symptoms (such as the fight-or-flight response) as it did in response to the initial trauma. A person may experience an emotional response before realising why they are upset. Frequently, triggers have a strong sensory association (a sight, sound, taste, or smell) or are associated with a deeply ingrained habit.

The Necessity of Social Support

The provision of assistance, services, and resources to individuals and communities by government agencies and officials is referred to as 'social support' in public administration. This support can take many forms, including financial assistance, access to healthcare and education, social services, and other forms that assist individuals in meeting their basic needs and enhancing their quality of life.

One of the primary functions of public administration is, among their services, to provide social

support to the most vulnerable individuals and communities. This may include developing policies and programmes that address social and economic inequalities, creating and implementing social safety nets, and collaborating with community and non-profit organisations to provide additional assistance to those in need.

Actual participation in diverse social relationships constitutes social integration. This integration includes feelings, closeness, and a sense of belonging to various social groups. According to experts, integration into such social relationships provides protection against maladaptive behaviours and negative social/health outcomes.

No matter in which department and in which area of public administration he is employed, as a civil servant he is obliged to take care of the acquisition of such social skills that will adequately complement and upgrade his basic work. These definitely include communication skills (verbal, non-verbal, written), assertiveness, empathy, resilience, the ability to solve problems and conflict situations, and especially the ability to work with demanding clients.

Types of Social Support Systems

Different forms and functions of supportive social networks exist in the lives of individuals:

During times of stress, emotional support can be especially vital.

When individuals have immediate needs that must be met, instrumental support is essential. And the third, important support is known as informational support. It may involve mentoring, guidance, advice, and information. People may feel less anxious and stressed about the problems they are attempting to solve if they have access to this form of assistance.

Serving clients with post-traumatic stress symptoms (PTSS) in public and administration services requires sensitivity and understanding. Here are some tips for providing appropriate care:

- **Be patient and empathetic:** Individuals with PTSS may have difficulty concentrating or communicating their needs. It is important to be patient and empathetic when working with them.
- **Create a safe environment:** Make sure the environment is calm and quiet, and minimise any potential triggers. Ensure that the individual feels safe and supported throughout the interaction.
- **Use clear communication:** Use clear, concise language and avoid using complex terminology or jargon. Allow the individuals to ask questions and take their time to process information.
- **Respect boundaries:** Individuals with PTSD may have specific boundaries or triggers. It is important to respect their needs and communicate any necessary information in a way that does not trigger their PTSS symptoms.
- **Offer support and resources:** Provide information about support groups or therapy options that may be helpful to the individual. Be willing to connect them with relevant resources or provide additional assistance as needed.
- **Seek training and education:** Administration services professionals can benefit from training and education about PTSS and how to interact with individuals who have the condition.

Overall, treating clients with PTSS in public and administration services requires understanding, patience, and empathy. By creating a safe and supportive environment, using clear communication, respecting boundaries, and offering support and resources, you can provide appropriate care to individuals with PTSS.

The importance of a network of support services

Trauma support systems in public services refer to the range of services and resources available to individuals who have experienced traumatic events, such as natural disasters, accidents, violence, or abuse. Trauma can have profound and long-lasting effects on the mental and physical health of individuals, as well as their ability to function in daily life. Public services, such as healthcare systems, social services, law enforcement agencies, and emergency responders, can play a critical role in providing support to individuals who have experienced trauma.

Some examples of community support networks that can serve and complement the public administration services in providing their services are presented:

- **Crisis hotlines:** Many public services offer crisis hotlines that individuals can call for immediate assistance and support. These hotlines are often staffed by trained counsellors who can provide guidance and referrals to other resources.

- **Emergency response teams:** Emergency responders, such as police officers, firefighters, and paramedics, often encounter individuals who have experienced traumatic events. They may receive specialised training in trauma-informed care and techniques to help individuals manage their emotions and cope with the aftermath of the trauma.
- **Mental health services:** Many public services offer mental health services, such as counselling and therapy, to individuals who have experienced trauma. These services can help individuals process their experiences, manage their symptoms, and develop coping strategies.
- **Victim services:** Many public services have victim services programmes that provide support and advocacy to individuals who have experienced crime or abuse. These programmes may offer services such as crisis intervention, safety planning, and help accessing other resources.
- **Social services:** Social services agencies may provide a range of services to individuals who have experienced trauma, such as housing assistance, food assistance, and job training. These services can help individuals stabilise their lives and begin to rebuild after a traumatic event.

Overall, trauma support systems in public services can help individuals who have experienced trauma access the resources and support they need to recover and rebuild their lives. These systems require ongoing investment and attention to ensure that they are effective and responsive to the needs of individuals in crisis.

5. IMPORTANCE OF COMMUNICATION

Public organisations face challenges related to dealing with large numbers of people, handling large amounts of information, and often long and complex processes related to bureaucracy that are a reality in many different countries. These factors can contribute to an impersonal approach. This practice can have particularly negative consequences for people affected by trauma. If your organisation wants to implement a trauma-informed practice or if you want to improve your individual practice, this chapter is for you, as it will help you understand the importance of communication and develop best practices.

It is often assumed that communication skills develop naturally with practice. However, an increasing number of studies have shown the importance of continuing education, training and supervision, as dissatisfaction with communication remains one of the most frequent complaints in care in different sectors and services.

The experience of a trauma (e.g., wars, natural catastrophes, violence, neglect, abuse) may alter people's behaviour from rational and balanced to socially less adequate, with manifestations of fear, criticism, anger, distraction, and the person may become depressed or anxious. In these cases, essentially concerned with self-preservation, people may forget what they have been told, refuse to accept unpleasant information, misrepresent simple information, criticise and complain. It is important to respond to anxiety and distress by paying attention and providing support.

In this context, communication should have some important characteristics. It is important to be alert and prepared. This process requires continuous education and training for everyone involved in the organisation, regardless of their position or status. It should also be a dynamic process adapted to each individual and to the characteristics of his or her experience at the moment of the interaction, as the individual's own needs change over time.

Below is a set of recommendations that should guide your interaction/communication with people who have experienced trauma.

Where to start with communication?

Keep in mind that dealing with a person who has experienced trauma is much more than changing the question from "what is wrong with you" to "what happened to you". Although changing this aspect is fundamental, it is now known that it is insufficient in itself. The following is a set of recommendations that can improve your performance in these cases:

- Learn more about trauma and how it affects people. Knowing that trauma affects people's thoughts, emotions and bodies will help you deal with reactions that you may have considered unexpected or inappropriate. If you come to see them as a reaction to trauma you will be more predisposed to act according to an informed practice.
- If possible, try to get to know your clients/students before you receive them. If you have access to information that allows you to screen cases, try to identify clients/students who have a history of trauma.
- Avoid any re-traumatising practice. Keep in mind that as important as knowing how to act in a crisis is knowing how to prevent or minimise its occurrence. Recognise the role of triggers (i.e., situations that activate vivid memories of trauma) in the activation of crises and eliminate practices that can function as such. If you feel prepared, when faced with manifestations of distress you can share calming and grounding techniques.
- Be attentive to the persons' verbal and nonverbal behaviours and adapt your behaviour to the first signs in order to minimise situations of escalating distress, anger or fear. Avoid reacting to the emotional state you identify in the persons by trying to change it or communicate that it is unjustified. Instead, try to recognise and accept their state, showing interest in listening to them if they want to verbalise what they feel.
- Use non-verbal communication to express attention, interest, and support. Postures such as leaning forward, looking at the person without being intrusive, nodding, saying 'hum-hum' to encourage further speech, smiling, appearing calm, receptive and attuned to the person's emotional state can be felt as empathetic.
- Being silent at times when the persons seems to be thinking or after providing information is important. Be aware that silences can allow information to be integrated, allow the persons to organise themselves, and give rise to new questions that people need to prepare for.
- Identify and link up with a network of services in your area that you can activate or refer to if the person expresses a need and desire. Always ensure confidentiality of information. Do not comment on what has been shared with you or what you have observed. If you do so because professional issues require you to do so, protect the identity of the person.
- Try to provide the information requested and allow the persons to participate in making decisions that concern them, rather than giving them a passive role. Allow the persons to feel in control of the situation, enhancing their skills and strengths and contributing to their empowerment. Provide complementary written information that can act as a memory aid. Take into account that people differ in the amount of information they need, so you should assess the need for information on a case-by-case basis. Do not overload the persons with information, but respond to what the persons want to know and watch for clues as to how the

information is being received. It may be necessary to reduce and/or simplify the information provided in order to reduce possible reactions of discomfort and discomfort.

- Know that talking about what has affected them or concerns them with a person who presents sympathy, support and validation can help individuals decrease feelings of discomfort, distress, and alienation. End by thanking them for sharing "Thank you for sharing this with me". Be aware that many people affected find it difficult to talk about what concerns them and may not want to. There are also cultural and gender issues that can intensify this reaction. In certain cultures, especially men may have been brought up not to talk about their feelings and not to ask for help. Avoid showing signs of frustration. Instead, in these cases it may help to:
  - say that their response/reaction is frequent, normalising it;
  - avoid asking detailed questions;
  - acknowledge the person's difficulty in talking, e.g., "I feel you are having a hard time talking about this";
  - provide the answer to the most immediate questions and concerns;
  - respect individual limits and boundaries;
  - focus on the person and see beyond the trauma.
- If possible, do not avoid emotional topics for your own protection, but always ask people if they want to address them. Do not devalue the person's experience and feelings. Allow the persons to cry if they feel the need to. Most people feel disturbed by another's crying and tend to try to stop it. Be aware that the release of emotion may bring some relief, encouraging the expression of concerns. Wait for the crisis to pass and respond in empathy. Be aware that you should not use clichés, guilt, or shameful language such as "You will soon feel better"; "Time will help"; "At least...". Do not tell the persons how they should feel or that they should not feel this way, avoiding expressions such as "You should feel..." or "You should not feel..." or "At least...".
- If you provide advice or guidance, avoid doing so in an imposing way. Begin by exploring what strategies have been used and how they have worked. Ask questions that may help the person to arrive at solutions on their own. Offer several alternative strategies such as "This strategy works for several people, what do you think?", "Does that seem like it would work for you?". Give hope where it is possible to give it, without false promises or inadvertent and premature reassurance, avoiding formulas such as "Everything will be fine".
- Avoid creating barriers to communication related to prejudiced attitudes and/or physical distance. Feelings of social inferiority can impede the asking of questions, the course of healthy communicational interaction and the establishment of a relationship.
- Avoid creating barriers related to cultural and linguistic differences. Avoid using slang, colloquialisms, abbreviations, local expressions, and explain technical terms if you use them. Wherever possible, provide services in the native language of the persons/ consumers and ensure that communication respects cultural differences.
- Make sure you do not use terms to describe the person's/client's behaviour that reflect judgement. Responses of non-attendance, aggression or criticism can be manifestations of trauma.
- When faced with someone who is angry or irritated, acknowledge that the person is angry and try to calmly analyse the reasons, responding with empathy. Be aware that easy criticism from the person can be an expression of fear, and that reacting in mirror image by reproducing an angry response can compromise the relationship and lead to escalation.
- Apologise if you are wrong. Admitting the mistake usually helps to ease the situation. In some cases, this response can be supplemented or replaced, especially if you were not directly involved in what occurred, by genuinely regretting what wrong has happened/is happening to the person, such as "I am sorry for the difficulties you are facing." Respond empathetically.

Empathic Response

Empathy involves responding emotionally to the other persons' emotions and understanding their experiences. It is generally considered to have an emotional and a cognitive component. The emotional component refers to a visceral, rapid, and involuntary reaction to the experiences of others, which needs to be sufficiently regulated. The cognitive component refers to the ability to understand the other's perspective. Research has shown that the feeling of being understood and of a shared emotional state has positive effects, particularly on health. For this, it is important that through your behavioural response you demonstrate that you are

feeling empathy, not just the subjective state of feeling it.

The empathic response may be organised into various components. They may be used in an isolated manner or combined in one or several moments of a communicational interaction:

- **Reflection:** Facilitates persons to start the conversation and to express what concerns them. For example, "I can see that this subject has worried you", "I can see that this is difficult for you to talk about".
- **Exploration:** Facilitates getting additional information. For example, "Do you want to tell me about it?" or "Can you tell me about it?"
- **Validation:** makes the other feel that your reaction is legitimate. For example, "I understand that you feel that way under the circumstances"; "Your reaction is perfectly normal.", "I understand that you feel that way."
- **Support:** Acknowledges the difficulty of the situation and goes in support. For example, "You have been through a lot... I want to help you in any way I can.", "I will do my best to..."
- **Respect:** For the strength the other person shows to endure their situation. For example, "You have dealt with all of this very well."
- **Alliance:** Brings the other to our side as professionals, to face the situation together.

Specific communication recommendations during the service:

Greet the person.

Look at the persons when they approach, without being intrusive.

Call the person by name and ask how he/she prefer to be addressed.

Ask the person how you can help.

Prefer open questions to closed ones, for example, "How are you feeling?" rather than "Are you feeling well?".

Show attention while you are listening by maintaining regular eye contact.

Demonstrate that you are understanding by returning what you have been told: "You told me that ..." or "I see what's bothering you."

If you are interrupted on the phone or if someone else asks permission to speak to you, ask for permission to do so.

Clarify issues you don't understand or that you are not sure you understand, rather than continuing. For example, "You said ... would you mind explaining further ...?" or "Can you give me an example ..." or "Would you mind telling me a little more about ...", "What do you mean by ...", "So what you are saying is ..., was it this? Did I understand you correctly?"?

Try to summarise the information by demonstrating that you have listened, checking your understanding and allowing the person to add additional information, such as "Let me get this straight. You told me that your main concerns were... and that you expect help to/with.... ".

Use "I statements", distinguishing fact from opinion, such as "I think...", "In my opinion...", "What do you think? Does it make sense to you?".

SUMMING-UP

People who have experienced trauma have gone through extreme situations that most human beings have never experienced. They often feel frightened, sometimes emotionally numb, and often separated from other people and unable to express what is happening to them. Finding available people, aware of how the trauma affects the individual and able to validate and acknowledge as real their suffering can be decisive for their inclusion and, hopefully, the path to their recovery.

6. ACQUISITION OF SOFT SKILLS AND CONFLICT MANAGEMENT

A trauma-informed approach in your contact with clients also depends on your skills level. It is important to develop awareness about trauma, but without the right skills it will be impossible to apply it in practice.

The pillars of trauma-informed interactions are safety, trust, choice, collaboration, and empowerment.

To ensure a trauma-informed approach especially in case of conflict, you as public service worker need a set of skills. You can train and improve the following skills with taking a course, or asking your family or friends to give you feedback on how you are skilled in conflict resolution or in interacting with them. Ask your employer if there is a possibility to support you with further improving your skills as a part of lifelong learning. Volunteering is another environment which could help you to improve your skills as a side effect. You can search for volunteering opportunities in your hometown, or sometimes there are possibilities of online volunteering.

As mentioned in previous sections, there is quite a large number of skills that a person uses when interacting with others. Let's sum up the most important skills within conflict management:

- Cultural competences Culturally sensitive trauma-informed care refers to the capacity for professionals working within public services to acknowledge, respect, and integrate clients' cultural values, beliefs, and practices. This also includes socioeconomic status, literacy level or related factors. Seek a solid understanding of the communities you work with (socio-cultural and socio-political histories, as well as current context) and centralise this cultural understanding in your work.
- Emotional intelligence is tied to a person's social skills, including social awareness, compassion, and appropriate interactions.
- In addition, it is important to develop a certain level of self-awareness – in other words it is mindfulness of cognitions, emotions, and behaviours. Self-awareness is a foundation for emotional intelligence. A trauma-informed approach encourages service workers to increase self-awareness. When persons are dysregulated (were impacted with traumatic experience and are out of their normal state), there is a decrease in awareness of thoughts, emotions, and behaviours. Dysregulation leads to a reliance on emotional reactivity rather than thoughtful responding. This is something, what public office workers should expect.
- Empathy is the ability to emotionally understand other people's feelings, to see things from their point of view and to picture yourself in their shoes. Basically, it is about stepping into someone else's shoes.
- With resilience you can deal with the challenges you face in a way that helps you not only to survive adversity, but also to recover from it. When you are resilient, you can bounce back from setbacks while keeping calm and in control. Why is resilience important? Your level of resilience defines your ability to approach the personal challenges you face from a position of strength and growth.

Triggers in connection with the conflict

Have you ever encountered something that reminded you of a past experience? For example, a smell that reminded you of a place or a person? How do you feel when you smell mushroom pasta? Possible answers are: reminds me of my friends; it makes me feel happy; makes me feel hungry; reminds me

of my family; makes me sick to my stomach; makes my mouth water. You probably could empathise with some answers, which are leading to different feelings like joy, hunger, disgust. To overcome them, you need to use emotional regulation, and your adaptability and flexibility, which are two of the very important assets and means adaptation to certain circumstances or triggers (external or internal).

Traumatised persons are probably unable to conceal the reaction to such a trigger, because of their sensitiveness. As a public worker, you need to take this into account and to be prepared for their manifestations. The situation, smell or sound could be a trigger, which causes reaction, good or bad, and it is very individual to the client's individual experience. As a public worker, you should learn how to regulate your own being and how to handle different situations.

This is connected to the possible conflict resolution. As the first step it is important to know your conflict triggers, so you will know how to change your response to conflict. There are six core identities in connection with triggers: competence, inclusion, autonomy, status, reliability, and integrity. When someone questions your skills or intelligence, when you are excluded from a group, or implies that you are not a good companion; when someone tries to control you, impose on you or threaten your self-sufficiency; when someone threatens or disparages your tangible and intangible assets; when someone is questioning your trustworthiness, moral values or integrity; these are possible triggers, which could put you into discomfort or anger.

Emotional safety for clients means that one feels accepted; it is the sense that one is safe from emotional attack or harm. Most trauma survivors have probably felt emotionally unsafe or had their sense of 'being all right' taken away by others.

You are not working as a psychologist, but as a public service worker, you are able to bring your client a sense of safety, understanding and empathy.

Collaboration skills cover everything it takes to work well with others and deliver results. These skills are important because possessing a high level of these can lead to avoiding conflict.

Communication is part of collaboration skills and especially active listening is one of the most important skills for a person working in the public sector. Active listening and allowing sufficient time for interpretation should be a matter of routine, regardless of the type of communication or communication channel chosen. It is important to listen without distraction, to listen for understanding by observing the consistency between spoken words and non-verbal expressions, and to seek clarification through feedback if there is any sign of misunderstanding. This can be challenging in a busy environment when there are several distractions such as the phone, a number of clients, more than one staff member, and many urgent tasks. Active listening techniques can be trained and practiced, and it is a skill set that is valuable in any setting.

Communication, also in a conflict situation, should follow several steps which were more deeply described in chapter 6:

- Respectful communication, as for example the tone of your voice, can influence how people perceive and react to a certain message or information.
- Respect the life experience of others. Acknowledge that persons' concerns or reactions may be based on "what has happened to them" and not because "something is wrong with them."
- Treat other people with dignity and respect.
- Be an active listener.
- Focus on behaviour and not on the individual.
- Use adequate body language.

Be aware that public speaking and dealing with public workers could be very stressful for a person with a traumatic experience. How can persons without psychological training help others when they register those persons are sweating, have a distant or resigned look, are nervous or are obviously disturbed by something?

In the beginning of the contact with a client, it is helpful to incorporate incidental elements into an appropriate and believable client-centred context, or simply a positive statement. The context of the positive statement could be the client's participation and punctuality, filling in the forms accurately, and thanking him/her for coming despite external factors (cold, rain or heat). A positive statement opens the way the conversation will go, making the client feel relaxed and welcome. You are creating an atmosphere of trust. Example: "I would like to thank you for your punctuality. I appreciate it very much."

The next step is explaining what is happening and what is waiting for a client to resolve his/ her need/ situation for which service has been sought. Give the client structure. In that way, the clients will have knowledge of what happens next, and this may give them a feeling of predictability.

Conflicts are common part of our lives.

In general, we can recognise five stages of conflict. At first, we need to recognise there is a conflict – recognise the trigger (for example incorrect appointment date or time for meeting at the labour office). Usually, the trigger is not visible, so you need to find a safe place to talk. The second stage is, when a person is aware there is some misunderstanding ongoing and you need to identify the source. In the third stage, the person after being aware, tries to perceive the feelings, ideally of both participants. You can use your skills in active and empathetic listening because there could be stress or some unpleasant feelings. This stage offers an opportunity to start to cooperate. The fourth stage is the actual communication with the aim to find solutions for the conflict, from which the phase of consequences crystallizes, which is represented by a common agreement between both parties (the fifth stage).

Resolving conflicts and communication strategies in conflict situation

What could a public service advisor do when conflict occurs? Remember, that you are often the first point of contact for clients in many situations. Using focused eye contact and engaging body language, you can establish open, non-threatening interaction including respectful personal space. Do not use confrontational language like arms crossing, putting hands on your hips, close approaching, physical touching, or cornering the client!

Ask open-ended questions to cover who, what, when, where, and how in relation to the subjects under discussion, and be attentive while clients respond. Maintain a pleasant tone of voice, an even pace of speech, and a pitch and volume appropriate to what is being communicated. The best way to avoid miscommunication is to deliver a clear, concise message that leaves no room for interpretation. Allow room for asking the questions to get clarification, so the client is on the same page. Communication with the use of examples, concrete descriptions, and FAQ-based explanations ensures there is no ambiguity or inference occurring.

Also, when the client is talking, please remember to avoid interrupting, making judgments, and do not try to correct things. Also, remember to concentrate on the behaviour and not on the person.

Using your skills (trustworthiness, reliability, collaboration skills, empathy, communication, etc.) could prevent secondary traumatic stress for clients.

Strategies of conflict management

Researchers list five models of conflict responses: collaborating, competing, avoiding, accommodating, and compromising.

A compromising approach is especially useful in a trauma-informed approach. Using "we" language is a good tactic that can help emphasize the need for compromise without appearing weak or as a person with power. It is a neutral way for both parties to commit to resolving the situation. It is beneficial to be as objective as possible by using neutral sources when collecting information about the source of the conflict. If you find yourself in conflict, with a co-worker, or a client, it is essential that you think about the personality traits of others. Some people respond well to disagreement, but others do not, especially with trauma behind them, and would struggle with their assertiveness. More power also means more influence. Do not forget that you are a public service employee, and you are there for the clients.

It is important to listen actively and empathically. Try to bring up several possibilities for how to resolve the situation and then try to find a solution which will be accepted by both sides. Give the client choice and with it you give him/her control.

Sometimes conflict management may be as simple as interrupting the negative feeling or feedback cycle by everyone taking a drink of water, which creates a pause and a sense of safety as the body resets itself.

7. PRINCIPLES OF REDUCING STRESS DURING SERVICE SETTINGS

It is likely that during your professional activity, you have dealt or will deal with people in psychological crisis because they are under the effect of a traumatic event. They may feel in a state of emotional and mental confusion, which can vary in intensity and severity.

A psychological crisis situation can be triggered by different triggers, internal (e.g., thoughts) or external (e.g., sounds, images, reactions of the interlocutor), which bring back vivid memories of the trauma. The thoughts generated by these real or anticipated events generally produce alterations in the body and emotions, which can configure a panic attack.

In a panic attack situation, the autonomic nervous system is activated, causing the persons to behave as if they were fighting for survival or physical integrity, their own or those they want to protect. Thus, changes to typical or habitual behaviour and functioning may occur. Even if the intense fear reaction is normal in these circumstances, the components of the anxiety response (increased heart rate, increased respiratory rate, increased muscle tension, creation of a state of alertness) can be interpreted as a threat. In this case, the individuals' anxiety response, instead of preparing them for action, may affect them negatively, termed dysfunctional.

The person may feel helpless and not know what to do to cope with the situation. Keep in mind that the origin of this episode may be a traumatic situation and do not judge or criticise. Respond with empathy.

In this section, we provide suggestions that can help you in your response to reduce stress and anxiety and its acute manifestation, including panic attacks or other situations triggered by potentially traumatic events. These techniques used in combination can enhance the desired effects of reducing symptoms and helping you to relax. They should also be practiced beyond the crisis situation, minimising its occurrence and maximising the effects of the technique. Additional specific activities are provided in the Resource Pack developed by our project.

Some of the manifestations of anxiety, particularly breathing difficulties, may be similar to manifestations of other medical conditions, such as asthma or heart disease, but the way of acting is different. If in anxiety situations, due to rapid shallow breathing (hyperventilation), there are excessive concentrations of oxygen in the blood, in the clinical conditions listed oxygen deprivation can occur. If in doubt about what is happening seek help by calling the European Emergency Number 112. During the call, answer all the questions you are asked (they are important for understanding the case) and follow the instructions you are given.

How to act in a psychological crisis

Whatever the cause, promote a calm environment, communicate calmly, and help the persons to control their breathing.

Help the persons to understand that they are going through a momentary crisis which may reach full intensity in about 10 minutes and last no longer than 20 minutes.

If the persons are able to move, help them to move away from the place where they are and triggered the seizure and sit up. If the persons are not able to move around, you can help them where they are, minimising public exposure.

The response to high stress and anxiety is to alter one's thoughts and body responses in order to feel better. Some strategies may be more effective for some people than others.

It is important that you try to control your thoughts by taking a rational view of them. It may help to think that it is a panic attack, that it will pass and that one's life is not in danger, especially if it is not the first time one is dealing with this situation. It can, however, be difficult for the persons to believe it, since, due to the physiological changes they are experiencing, they may have a sense of imminent death and intense fear.

In this case, it is important to give the persons a focus that helps them to anchor themselves to reality, and to help them control their breathing.

Rapid and shallow breathing during a panic attack (hyperventilation) can aggravate symptoms due to increased oxygen concentrations and reduced carbon dioxide in the blood. Although this is generally considered a harmful gas, its values should be kept within certain levels so that sensations such as breathlessness do not occur. In these cases, it is important that the person breathes slowly and for a long time, stopping hyperventilation, which will reduce the symptoms.

Breathing Control Technique (diaphragmatic or abdominal breathing)

This type of breathing should be done through the abdomen ('belly') with the help of the diaphragm,

enhancing the benefits of breathing and helping to calm down.

Encourage the person to breathe in through the nose slowly and deeply (on a count of 4), so that with the air they inhale, the belly sticks out (watch the belly inflate as if it were a balloon). It may help, if the person can, to place one hand on the stomach to see if he/she is performing the technique correctly.

Hold the air in for 4 seconds.

Then, when you exhale, you should let the air out through your mouth, and your stomach should go inwards. If necessary, you can press slightly with your hand.

You can help by applying slight pressure inwards with the hand on your belly. Expiration should be slower than inspiration.

It may be helpful to accompany the person in these exercises, adopting the breathing technique at the same time as the person.

Mindfulness: Focusing on the here and now

A mindfulness practice that can be used in these situations is called 'here and now'. In a panic attack situation, to help the persons calm down, you can suggest focusing on:

- Five things they can see:- describe to him or herself the colour, shape and size of the objects you select
- Four things they can touch; - for example, feel the texture of an item of clothing you are wearing
- Three things they can hear
- Two things they can smell
- One that they can taste.

Promoting a focus: simple strategies

Simplified versions of the previous strategy consist of asking the persons to:

- look for a nearby object with their eyes and describe its colour, shape and size to them.
- focus on different physical sensations, such as feeling an object in their hands (for example, the texture of the clothes they are wearing).
- invite him/her to tell you a story.

By doing this you help the persons to take the attention off the bodily symptoms until all sensations disappear and they calm down.

After the crisis has passed

Respond in empathy.

Help the persons to accept the way they felt and avoid blaming themselves.

If it makes sense and/or is asked for, you can provide valid and documented information on strategies that they can use to help them identify their needs and respond to them, such as progressive muscle relaxation; talking about what happened and how they feel with people close to them or who have been involved in the traumatic situation; writing about it; crying, if they feel like it, rather than repressing their emotions; doing things they like; establishing/returning to daily routine; considering the need and interest of seeking psychological support.

8. ENHANCING SELF-AWARENESS AND SELF-PERCEPTION

Basics of self-awareness

Philosophers have pondered about the relationship between mental and physical health for centuries. Science now acknowledges the mind-body connection, and researchers continue to find evidence that our thoughts, feelings, beliefs, and attitudes, as well as how we deal with stress, can affect our physical health in a positive or negative way.

"When we focus on ourselves, we evaluate and contrast our current behaviour with our internal standards and values. We develop self-awareness as impartial evaluators of ourselves"[10].

This five-layer model provides an ideal framework for self-awareness theory and practice. This model asserts that we are much more than the interaction of a mind and a body:

- **Layer 1 Physical:** your body and surrounding environment. This is who you are, including your size, shape, gender identity, race, and ethnicity. The systems of your anatomy and physiology make up your body. This layer also consists of your environment and the world you perceive with your five senses: sight, hearing, taste, smell, and touch.
- **Layer 2 Energetic:** your breath and energy levels. The oxygen you breathe nourishes and sustains your body and brain. Your energy is the invisible life force that animates you on all levels and enables you to think, create, move, work, and navigate the good, bad, beautiful, and ugly that life brings.
- **Layer 3 Mental:** comprises your thoughts and emotions. This is how you experience and express your emotions, as well as how you think and what you think about. They influence your worldview, actions, and experiences of yourself, others, and life.
- **Layer 4 The Witness:** is your capacity to observe and perceive each layer without judgment. The Witness is an ally on the path to self-awareness, comprehension, and healing. When you observe your thoughts, emotions, and behaviour without judging them, you are better able to recognise and comprehend the origins of harmful habits, patterns, and beliefs. Consequently, you make (or do not make) more informed decisions or adjustments. The Witness is an indispensable element of self-awareness.
- **Layer 5 Bliss:** is your connection to something greater than yourself. This may be spiritual, religious, or rooted in a healthy passion or the natural world. It is the highest level of self-awareness and is often described as the experience of interconnectedness with all that is or your personal understanding of the divine.

Self-awareness requires us to:

- Have a clear understanding of our personality, feelings, desires, quirks, and flaws;
- Observe and comprehend the messages we receive from our body and our environment;
- Connect with our breath and energy and observe how they affect and are affected by our lifestyle and decisions;

Observe the mind and emotions, distinguish between thoughts and emotions, and find ways to respond rather than react to life's challenges;

10 Duval, S., & Wicklund, R. A. (1972). A theory of objective self awareness. Academic Press.

- Awaken The Witness (intuitive wisdom) and apply it to the first three layers in order to accept ourselves with clarity and without judgment;
- Discover our own unique connection to something greater than ourselves.

When this skill is used, we see our reality as it truly is, without a veil of denial or wishful thinking. Then, we choose consciously to make changes, to remain unchanged with full awareness of the consequences, or to find acceptance and inner resilience if change is not possible.

Cultivating self-awareness

Self-awareness is not a trait that is either present or absent. It is a skill that develops over time. One can be self-aware of many things, including:

- strengths and weaknesses,
- when succeed or fails,
- one's thoughts, feelings, and behaviours,
- one's most common cognitive distortions,
- how these things interact and relate to one another.

A person can have heightened self-awareness in one area while being unaware in another. Consider, for instance, a person who suffers from mental filtering, a cognitive distortion that causes us to see only the negatives and ignore the positives. This individual may be acutely aware of his/her weaknesses and failures but ignorant of his/her strengths, successes, and thought patterns. The outcome is a mind-set that can fuel depressive episodes and ruminating. Therefore, when cultivating self-awareness, it is essential that the objective creates equilibrium and emphasizes non-judgment. Self-awareness that arises from a place of non-judgment enables us to make informed, decisions free of guilt and shame. It enables us to access a clear vision of our reality without denial, and it can be very empowering.

The importance of self-Awareness while dealing with trauma

Neuroscience research indicates that the only way we can alter our emotions is by becoming conscious of our inner experience and learning to befriend what is occurring within us. Without self-awareness, trauma-informed practice is impossible to provide. Self-awareness is a requirement for it.

Self-awareness is one of the key components in trauma-informed practice. When we lack it, we frequently make the situation worse, even if our original intention was to assist the individual experiencing a trauma response. Without self-awareness, we tend to be triggered by others' trauma reactions. Our elevated state contributes and adds to their dysregulation.

When we are dysregulated, we lack self-awareness. In such situations, we are typically unaware and unintentional in our words and actions.

Consider instances in which you witnessed someone else experiencing a trauma response. They were utterly unaware of what they were saying and doing at that particular moment. They did not know what they needed to calm down or even if they were calming down.

Through self-awareness, however, we are able to help people in need while also supporting ourselves. Self-awareness enables us to maintain composure in uncomfortable situations. It allows us to govern both ourselves and others. Self-awareness enables us to make better decisions and access a deeper understanding of what is occurring within and around us.

Considering the concepts of trauma brain and executive functioning, we realize that these two mental states cannot coexist. When persons are experiencing a trauma response, they are unable to utilize their executive functioning skills. They cannot think logically or create future plans. Their thought process is jumbled. They lack self-awareness. Being trauma-informed and trauma-responsive is a complex endeavour. Thus, if you want your workplace to be trauma-informed, you must first improve your self-awareness.

Relationship between self-awareness and resilience

All humans are subject to some form of a traumatic situation that has far-reaching consequences. Raising awareness of trauma is a great way to provide support for those who have endured traumatic situations, as each individual responds to trauma in a unique manner.

Facing a traumatic event has far-reaching effects. There are many factors that influence how people react in these types of situations; a deeper understanding of trauma is an excellent method for providing support to traumatised persons.

When we encounter a person who has been affected by trauma, it is extremely challenging to understand parts of their behaviour. They may be erratic, panicky, withdrawn, hyperactive, or even violent. Some of their emotions may appear out of control or alternate between calm and hypervigilant states. When we attempt to reason with these persons, we are frequently met with fury or verbal abuse. In these situations, it is really difficult to know how to assist them. In such circumstances, it can be challenging to be both a caring and responsible professional. We do not want people to be out of control and incapable of regulating their emotions and actions. That is a severe double bind[11] that is frustrating and difficult to process inwardly when the other is in the heat.

In such situations there is a propensity to address the behaviour with intensity, to argue, to insist that they listen, or to yell a command for them to immediately change. Frequently, if they do not cease their behaviour, we conclude that they are disrespectful, and the confrontation can quickly escalate into a power battle. At that time, it is expected that there would be a winner and a loser, as this will have evolved into a competition. However, in a brain with dysregulation, the majority of activity is unconscious and unintended. It is ingrained in us to discover a way to withstand a perceived threat, and it can be a natural response to high-threat situations.

Accepting the things over which we have no control and recognizing the things over which we do have control are two crucial aspects of resilience. It is through self-awareness that a clear understanding of where our inner power ends and begins is possible. It is embodied by the sentiment "I cannot alter how other people behave, but I can change how I respond to them". Hence, self-awareness is also an essential element of radical acceptance and empowerment, which foster resilience.

Trauma resilience is the capacity to recover from traumatic experiences and thrive despite adverse life circumstances. Most individuals are resilient in the face of adversity, but the capacity to thrive is contingent on numerous individual, situational, and contextual elements. General traits that foster resilience include:

- adaptability,
- the capacity to experience pleasant emotions,
- humour and inventiveness,
- sense of heritage, history, and tradition,
- spiritual and/or religious beliefs,
- warm personal relationships,
- a sense of self-efficacy.

Although there is no way to prevent traumas from their occurring, increased awareness of trauma helps individuals receive the help and resources they need to rehabilitate after experiencing traumatic events.

Self-perception and trauma

Self-perception is the persons' views of their self or of any of the mental or physical attributes that constitute the self. Such a view may involve genuine self-knowledge or varying degrees of distortion, also called self-perception.

Trauma causes individuals to rethink their perceptions of themselves. Survivors of trauma frequently struggle with low self-esteem and negative self-belief. People may perceive their bodies differently, experience feelings of inferiority or inadequacy, be self-critical or judgemental, or even develop self-hatred!

11 The double bind is often misunderstood to be a simple contradictory situation, where the subject is trapped by two conflicting demands. While it is true that the core of the double bind is two conflicting demands, the difference lies in how they are imposed upon the subject, what the subject's understanding of the situation is, and who (or what) imposes these demands upon the subject. Unlike the usual no win situation, the subject has difficulty in defining the exact nature of the paradoxical situation in which they are caught. The contradiction may be unexpressed in its immediate context and therefore invisible to external observers, only becoming evident when a prior communication is considered. Typically, a demand is imposed upon the subject by someone whom they respect, but the demand itself is inherently impossible to fulfill because some broader context forbids it. For example, this situation arises when a person in a position of authority imposes two contradictory conditions but there exists an unspoken rule that one must never question authority. Source: Wikipedia.

Trauma unquestionably affects one's relationship with oneself and challenges and alters one's self-perception. Before a traumatic event, it is typical to have confidence in one's ability to make good judgments, exert control over one's environment, and maintain safety. Trauma destroys these beliefs and leads to new ones, especially the inability to rely on one's own judgment: if you once considered a situation, person or behaviour to be safe and then it turns out to be traumatic, it is easy to believe that your actions cannot change or affect things, that you are not in control of your life and that forces beyond your control determine your safety.

We act in this manner as a result of a self-belief formed in response to a negative event. Trauma experts believe that all types of traumatic experiences contribute on how individuals perceive themselves. Trauma disorients the mind:- It produces illusory realities,

- Distort the truth,
- Causes individuals to doubt their perceptions of themselves.

Survivors of trauma frequently struggle with low self-esteem and negative self-belief. People may perceive their bodies differently, experience inferiority or inadequacy, be self-critical or judgemental, or express outright self-loathing. Those who have experienced traumas such as sexual, physical, mental, or domestic abuse, surgeries or significant body disorders, or accidents tend to have more distorted self-perceptions. Yet, any type of trauma can alter an individual's self-perception. Trauma creates alterations in the brain's physiology that disrupt emotional connections and distort cognitive capacities.

Trauma isn't rational therefore the subsequent thoughts, actions, and beliefs are not rational. If victims of sexual trauma were once self-confident, they may perceive themselves or their body as a problem in the future. If victims of a car accident had perceived themselves as brave, they may afterwards perceive themselves as worried.

Basic self-care for TIP in public services

We must endeavour to gain an awareness of our weaknesses, and we must be cautious with our expectations. These skills that allow us to maintain composure and perform well on the job - the very traits that people admire most about us – can also lead us to undesirable roles as secondary victims of the traumatic incident. How can we attempt to avoid these issues? We can begin by identifying what pushes our buttons and sets off our individual reactions to trauma. The majority of factors involve similarities and links with our lives. They can be activated by sights, sounds, and smells. Additional triggers include recent life events (still coping with the death of a family member or friend) and musings on our own concerns and mortality (what if...). These circumstances should not be misunderstood as an opportunity to escape from stress/issues or to resolve past life occurrences.

In public institutions, public and administrative employees must be able to detect and 'control' their anticipated emotions. Over-identification with the victims can be one of them (everything starts to seem personal). When similar signs are present, individuals may have a sense of déjà vu and respond with "Here we go again?". They must also be prepared to tolerate the difficulties posed by their own unfulfilled goals and their recurrent need for closure. Traumatic occurrences can induce feelings of powerlessness and loss of control. When things are not going as smoothly (or as perfectly) as desired, they must resist the natural inclination to berate their own egos.

When workers are repeatedly exposed to a traumatic experience in the workplace, even if only by observing a client's reaction to trauma, they must hone their stress management skills and practice self-care, which may include supervision. However, some of them may be at even greater risk, particularly in the early stages of their participation. The enhancement of their coping skills is particularly crucial for them. Let us highlight two effective strategies in this regard:

- **Defusing** is the process of resolving a conflict through dialogue. It functions similarly to removing the fuse from a bomb (or an explosive situation) by allowing victims and workers to express their disaster-related memories, stresses, losses, and coping strategies in a safe and supportive environment. Often, making eye contact with a person who needs to speak is sufficient to initiate a conversation. The employee must simply

be present, listen, and provide support. Typically, the defusing process involves informal and ad hoc sessions. Even though they are typically brief and immediate, defusing sessions frequently become mini-debriefing sessions and may adhere to one of the formats described below. Because the allotted time is frequently inadequate, it serves as a starting point. Often, additional intervention is required, which can range from providing ongoing support (e.g., briefly touching base with the individuals/groups in the coming days/weeks) to scheduling and conducting formal debriefing sessions.

- **Debriefing** is a formal, individual, or small-group meeting. Typically, it is held shortly after an unusually stressful event for the sole purpose of dealing with the emotional aftermath. It is acceptable to use any location that is large enough to accommodate the participants and can be secured to ensure their privacy. This session may necessitate a time block. Typically, debriefing sessions are held within the first 24-72 hours after a traumatic event (experience), with follow-up sessions occurring as necessary. Everyone involved in the traumatic event should attend the debriefing whenever possible. When certain types of incidents occur, attendance at defusing and debriefing sessions is often recommended or even required by many organisations.

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