

Plain Language Text for *Trauma Informed Care in our Communities*

Note- **This text contains discussions around trauma, racism, and ableism.** During the original performance, Vo encourages the viewers to take breaks when learning about this difficult information. Please feel free to do the same when reading this document. You can also read it multiple times or come back to it when you are comfortable.

Who is Vo Vo?

“I identify as someone living with intersecting physical processing and emotional disabilities. I'm also queer, non-binary, transmasculine and an immigrant. I was born in Aotearoa. On my mother's side I'm descended from the Han tribe. On my father's side I'm descended from Indigenous farmers from the Mekong Delta whose cultural identities and records were erased due to colonization. My experience and perspective is largely non-North American and one of working for communities in large, highly populated cities.

I started my education career teaching at a center for children living with autism spectrum disorder (ASD) in Sydney, Australia, and working with elementary school children with disabilities in Kathmandu, Nepal and Vi Thanh, Vietnam.

My processing disorder means that I might get overwhelmed when there is a lot of incoming information from different channels.

My pronouns are they/them/theirs. I've trained and consulted with organizations and universities about inclusive practice in the UK, USA, Finland, Sweden, Germany, the Netherlands, Australia, Nepal, Vietnam, Mexico, and Denmark since 2009. I've written publications around race, trauma, transformative justice and de-escalation, focusing on building resilience in Black communities, Indigenous communities, and the communities of People of Color.

And I'm a survivor.”

transmasculine- someone who was assigned female at birth, but identifies more with some degree of masculinity.

Aotearoa- Maori name for what is colonially called New Zealand.

What is trauma and how does it affect people?

Trauma is when an individual or community experiences, witnesses, or is confronted with an event that involves death or serious injury, or a threat to the physical safety of self or others. Trauma can be a daily or constant experience for many people.

Examples of systems or institutions where ableism and trauma crossover that were shared by both Vo and the audience:

- Education systems, including post-secondary education and special education programs.
- Medical systems including provincial health care, therapy, and hospitals.
- Employment systems and labour industries.
- Systems that distribute the arts and information (even this performance).
- Mutual aid work.
- Housing systems.
- Social work, social services, welfare and family support systems.
- Banking and credit systems.
- The cis-hetero-patriarchy.
- Dominant cultures.
- White supremacy or whiteness.
- The non-profit industrial complex.
- Judicial systems.
- U.S. Imperialism.
- The wealth class system.

One participant even noted that all systems have this crossover between ableism and trauma.

ableism- discriminating against people with disabilities and in turn favouring people who don't have disabilities.

cis-hetero-patriarchy- a system that privileges men, people whose gender matches the one they were given at birth, and heterosexual people.

non-profit industrial complex- the relationships between non-profit groups, governments, and businesses. This often has to do with funding.

imperialism- when one country tries to expand its power or control to other countries.

What are Trauma Triggers and Trauma Responses?

A **trigger** is something that prompts recall of a previous traumatic experience. Triggers can be almost anything, including physical or environmental elements. Some possible examples of triggers include:

- Transitional times in one's life.
- Having resources taken away.
- Being denied access.
- Others not following through.
- Others not responding.
- Invasive questions.
- Lack of privacy or confidentiality.
- Touching without consent.

- Authority figures, authoritarianism, or uniforms.
- The atmosphere of a place.
- Someone's tone.
- Dominant cultural norms.
- Indicators of whiteness, ableism, or the patriarchy.
- Anything else that reminds you of a time that felt threatening.

Triggers can cause folks to feel threatened or scared leading to automatic **trauma responses**. These are unconscious behaviours which have proven to be helpful in the past or have led them to safety. These aren't things that people decide to do. Typically, trauma responses fit under three categories:

1. **Fight**- Includes rejecting behaviors, arguing, aggression, anger, hyperactivity, fidgeting, or anything that attempts to reject the thing that is happening.
 2. **Flight**- Describes a vacating behavior, or trying to get away from the thing that's happening. It could be social isolation, avoidance of others, or physically moving away from the situation.
- Freeze**- Describes freezing reactions of the body, mind, or emotions. This can include disassociation, being emotionally distant, or being unresponsive. **Fawn** is a sub-set of the freeze reaction. It's when people take the path of least resistance. This can look like over-compliance, going along robotically, or a denying one's needs.

To repeat, these types of responses are automatic and not controlled. They're not decisions. They're a natural trauma response when there is a trigger.

What is Trauma-Informed Care?

Trauma-informed care is the recognition of the prevalence of trauma. It is the assumption that trauma is everywhere and that ableism and trauma intersect in almost every system that we exist in. It's knowing what automatic responses can look like and understanding that anything can be a trigger. Then we can start to understand, acknowledge and validate people's trauma responses.

For this to be fully realized, we need to see that all of the following are intrinsically linked: trauma-informed care, anti-racism, dismantling colonialism and anti-blackness, disability justice, anti-capitalism, abolition and harm reduction.

Here are the first five **principles of trauma-informed care**, as shared by Trauma Informed Oregon (<https://traumainformedoregon.org/>), and a sixth principle added by Vo. They also elaborate on these principles by tying each of them to disability justice.

1. **Safety**- ensuring physical and emotional safety.
Principle in Practice: having a welcoming common area and respecting privacy, having bodily autonomy, confidentiality, consenting to information being shared, and not outing people.

2. **Choice**- individuals have choice and control.
Principle in Practice: individuals are provided clear and appropriate messages about their rights and responsibilities, giving people processing time, having extra time built into procedures, having more explanations, letting people use different processes, using different ways of communicating, being transparent around context and future expectations, and offering opportunities for questions.
3. **Collaboration**- making decisions with individuals and sharing power.
Principle in Practice: individuals play a significant role in planning and evaluating services (they get to choose what happens to them as opposed to it just happening to them), people feeling empowered and autonomous, making opportunities for people to have input.
4. **Trustworthiness**- having task clarity, consistency, and interpersonal boundaries.
Principle in Practice: maintaining respectful and professional boundaries, treating everyone with dignity and respect.
5. **Empowerment**- prioritizing empowerment and skill building.
Principle in Practice: providing an atmosphere that allows individuals to feel validated and affirmed, giving benefits that can meet individual needs (not just a one-size-fits-all solution), giving people knowledge and skills so they can make their own decisions and continue to educate their own communities, building mutual aid (which will be discussed more later).
6. **Cultural historical and gender issues**- includes leveraging the healing value of traditional cultural connections and recognizing and addressing historical trauma.
Principle in Practice: not having a dominant culture of whiteness or an expectation of whiteness as the default, making space for and embracing non-western approaches, non-colonial approaches, and Indigenous approaches, validating these as legitimate approaches.

Examples from the audience of where disability justice and trauma-informed care intersect:

- Flexibility and letting people share as much or as little as they'd like.
- Meeting people where they're at.
- Psychiatric survivor communities and anti-psychiatry.
- Providing food for folks who can't obtain it themselves.
- Caremongering, or intentionally offering help to those that need it the most at difficult times.
- CONSENT CULTURE!!

Building Resilience through Trauma-Informed Care

By looking at everything through a trauma-informed lens, we can help build resilience in ourselves and others.

Resilience is the ability to bounce back stronger than ever. We may continue to experience trauma, display trauma responses, and we may be exposed to further trauma. Yet when people recognize, acknowledge, understand, and validate these traumas and responses, we can develop resilience. This is done through building on the strengths or the skills that we've developed over our lifetimes, and on the moments where we feel good about ourselves.

Resilience can include:

- psychological resilience
- emotional resilience
- physical resilience
- community and cultural resilience

Things people and organizations can do to help trauma survivors build resilience:

1. **Recognizing coping strategies-** Skills that build resilience can also be called **copng strategies** or **survival skills**. Coping strategies evolve out of trauma responses. They are developed long-term, sometimes even over generations. They can include:
 - Creative expression.
 - Adapting quickly to changes.
 - Resourcefulness.
 - Self-reliance.
 - Learning to camouflage or not be noticed.
 - Hypervisibility, like taking charge or being a leader so you are indispensable.
 - Perceptiveness, or heightened observational skills.
 - Pouring oneself into work or service, such as helping or educating others.
2. **Using a strengths-based lens-** This means reframing people's behavior. Instead of focusing on flaws we think people might have, we can focus on people's abilities and strengths. This will affirm the tools they've used their whole life to get to this point. For example:
 - Saying someone is 'determined' instead of 'argumentative'
 - Saying someone 'cares deeply about a situation' instead calling them 'over-emotional'.
3. **Highlighting cultural strengths-** Similar to the last strategy, you can look at whole cultures and communities through a strengths-based lens. Again, we can validate and recognize people's trauma responses as strengths. For example:
 - Saying a community is 'self-reliant' instead of calling them 'avoidant' or 'proudful.'
 - Saying a person fighting for their family's wellbeing is 'a strong advocate' instead of 'demanding' or 'needy.'

4. **Building community** - We build communities to debrief, to share experiences, to share our burdens, to feel less alone, and to feel witnessed. These kinds of supportive communities lead to mutual aid and community care.
5. **Building mutual aid and community care**- Mutual aid and community care shift our focus from individualism to collectivism. These types of care mean knowing how to show up for different people with varying needs without patronizing or infantilizing anyone. Community care equalizes power dynamics instead of treating some people as superior (which is often expressed as a “savior complex”).

Communities of people can support each other by providing things such as money, medication, self-medication, therapy, food, healing, joy, technology, housing, transportation, access and accessibility. They can help each other with their pets, their kids, or even help each other to support their friends or their neighbors. Community care can mean reaching out to our friends, neighbors, chosen family, colleagues, and family (if that's an option).

6. **Focusing on celebration and healing**- We should focus on celebrating people in their full humanity, with dignity and respect. This means showing and receiving appreciation, celebrating successes, and even celebrating mistakes.

Two examples of strategies that focus on celebrating and healing are gardening, and accessing ancestral wisdom.

7. **Making it sustainable**- When building a practice of care, be aware of burnout- exhausting oneself over time, draining your energy reserves, and taking on vicarious trauma. When you build care systems, also try to look after your own emotional reserves, energy, and capacities.

We also need to build awareness of the invisible educational, emotional, cultural, and physical labor pressed on folks dealing with trauma, racism, ableism, sexism, and many other prejudices. We should give them compensation, reward, validation, and credit where these things are due.

Collectivism- thinking about the needs of a group of people before thinking about ourselves.

patronizing- in this context, acting as if you are helping someone but only to make yourself feel superior.

infantilizing- when people are treated like children as opposed to autonomous adults due to stigma and stereotypes.

savior complex- feeling the need to “save,” or “fix” people, even if your help is not always useful or needed. These actions can start out with good intentions, but cause a lot of harm.

vicarious trauma- When you start to absorb other people's trauma as your own. This can happen when you're an empathetic person.

Questions from the audience after the performance

Q- How do we build awareness of invisible educational, emotional, cultural, and physical labor?

A- Like any conversation around power dynamics of any type, it's about building the vocabulary and the opportunity to discuss and address them. This needs to be an intentional process of building regular spaces and times to address these things, not just forgetting them once we've learned about them. Think about the ways people can build checks into their relationships, their connections, their jobs and their everyday conversations to share about and be asked about these kinds of labour. An example would be having a structure where supervisors and organizations understand that it is their role as a collective entity to ask, "What could we be doing better to support you?" or say "I've noticed that you're working a lot lately. That's a problem we've created. Tell us how we can create conditions where you don't have to work this much."

Q- So often therapy is very westernized and doesn't consider trauma-informed care specifically for POC and disabled folks. Any advice for informing therapists about this type of work?

A- Resources on trauma-informed therapy for POC and disabled folks are something I see people currently building, but a lot of those resources aren't complete yet. I'm currently working with Trauma Informed Oregon, and they have a huge website of resources. I know that they are working on adding resources for disabled and BIPOC folks. <https://traumainformedoregon.org/>

Q- What are some best practices and general tips for avoiding vicarious trauma (taking on other's trauma)?

A- That's a really big question. One practice is a separation. This can mean boundary-setting and a separation of personal practice, professional practice and community practice. I know that's a very colonial answer but it's important to have a reserve of energy for yourself because you are an entity as well. I think many of us are very focused on caring for others, and that is a beautiful thing to preserve. Sometimes we care for other people to the detriment of ourselves. I like to tell people, "I know you want to give a hundred percent, but how about giving ninety percent and then holding onto ten percent so that you can make it to the next day?" That's a very basic approach.

On top of that you can build regular healthy practices of engaging in things that you love or that feel good to you. That can be petting a cat, grounding (if that practice is useful to you), or calling somebody that you know will listen to you when things are rough. It really is personal- these things will be different for everyone.

Q- How do you deal with competing trauma responses?

A- That answer is similar to the one about invisible labor. We need to name the things that are happening, build awareness, build vocabulary, and build conversations. We can then practice ways of boundary setting when there are competing trauma responses. Overlapping trauma responses happen quite a lot, and can escalate one another. Folks sometimes need to disengage for a second to break the cycle. For example, someone else can step in instead of you if you're dealing with a customer or client . Building awareness and then practicing de-escalation can change this cycle.

Q- What are some good resources to learn more about trauma-informed care?

A- These resources are often missing. I would point out Trauma Informed Oregon again. I should also mention my book, which was released a couple of days ago. I made a graphic novel that discusses how to hold space called *Trauma X: Holding Space Radically* by Vo Vo. (This book can be purchased here: <https://fixmyhead.storenvy.com/products/30702403-trauma-x-holding-space-radically>)

Q- What should I do if an agency is receiving funding to provide trauma-informed, non-violent care but they are not following these principles and practices? Can Trauma Informed Oregon help by stepping in or educating? How can survivors make sure they receive proper care?

A- I don't have a definitive answer for that, but I think that Trauma Informed Oregon would be open to hearing from you or anybody else. They do intervene when services aren't providing trauma-informed care. So, my answer is I don't know, but that's a good starting point.

Q- Sometimes, when I'm trying to compartmentalize to help myself with vicarious trauma, I wonder if some of what is so difficult is an experience of collective trauma. It's like we don't have what is needed to stop the structural harm from reoccurring. Can you speak about vicarious trauma versus the collective need for well-being?

A- Yes I think we have to make choices every day between holding space for collective trauma versus blocking it out to some degree. I know that's a very brutal answer but we need some balance. This can be focusing on your immediate community or narrowing that lens just for a moment so that you're not constantly holding space for collective pain and trauma, including that of colonization and white supremacy.

You can also address the collective need for well-being by leaning on celebration, healing, and caremongering. We can think about trying to balance the scales, so we

are spending more attention and time on caremongering, mutual aid, celebration and healing, and then only holding space for collective trauma when we have the capacity. That's a hard thing to say, but I worry about people's capacities all the time.

As another audience member points out, so often vicarious trauma is in our intimate lives where those boundaries are harder to create, distinguish, and maintain. Boundary setting is a lifelong journey and a lifelong learning process.