1. Trauma Informed Care

Common/Traditional View	Trauma-Informed View
Students choose behavior and need consequences	Students want to do well but lack the skills or have learned bad behavior patterns
Characterizes student behavior negatively (i.e. manipulative)	Characterizes student behavior constructively (i.e. needs calming strategies)
Uses labels to describe students ("EBD")	Reframes behavior to identify strengths
Authoritarian	Collaborative
Minimizes coping strategies	Behavior is communication and serves a function
Academics focused	Whole-student focused
Student should already know the expectations	Teaches and re-teaches expectations using differentiation
Creates systems that make students work for support	All students receive support regardless of their needs
Staff-centered environment	Student-centered environment
Uses jargon with parents and non-educators	Uses language so that all can understand

How Thinking and Attribution Change with Trauma-Informed Care

SURVIVOR DOES	ATTRIBUTION BY NON-TIC	TIC ATTRIBUTION
Gets mad “easily” (also a judgment).	Always wants his/her own way.	Understanding that fear underlies anger. Asks what is scaring the survivor.
Does not want to change clothes for bedtime.	Refuses to follow the rules. Challenges caregivers.	Survivor fears for her/his safety. Feels best (safer) with street clothes on.
Now has boundary issues, and wants too much physical touching & hugs.	Acts like a baby, is manipulating, doesn’t know limits for affection.	Needs reassurance including healing touch and closeness.
Acts uninterested, does not pay attention or is disobedient & defiant.	Has become obstinate and likes to challenge authority.	Seeks safety in isolation, often feels overwhelmed and keeps to self.
Is disobedient, always breaking the rules.	Always seeking attention. Likes to challenge the rules.	Seeks support and help. Rules sabotage healing.

Embraces understanding of the role trauma plays in life of survivors/clients served.

Knowledgeable about the effects of trauma upon survivors both short- and long-term.

Familiar with concept of triggers, learns each client's triggers

Embraces philosophies of "do no harm," kindness in interactions & R-E-S-P-E-C-T.

Uses healing modalities to actually improve safety and feeling of safety. (no pretending one is safe while in custody, for example)

Enhances choice, options, expression of feelings, empathy, consideration, honesty.

Allows carer, when in doubt to say, "I don't know, and I will find out."

Good supervision invites reflection, consideration of alternative perspectives, imagined "do-overs" and no-fault explorations.

TIC Recommendations
Do's and Don'ts

Do	
Invite conversation	Allow silence
Allow expression of emotions	Stay with survivor in their pain, or "sit with them in the muck"
Ask "What can I do for you now & later	Say "I don't know" (answering, "why did this happen to me" etc.)
Ask what has brought comfort in the past and if this can be accessed now.	Reflect and clarify to be sure you understand
Offer options to feeling better & healing that you can cause to be available (referral to a therapist, go for a walk, breathing exercise, drink some tea)	Ask, "What would you prefer I ask you?" or "Am I asking the right questions?"
	Focus on behavior, rather than identities eg. "the abusive behavior", not "the "abuser"

TIC Recommendations
Do's and **Don'ts**

Don't	
Demand eye contact	Get too close
Talk too much	Ask too many questions
Make promises you cannot keep (I'll make sure you are safe.)	Use platitudes (this will make you stronger later)
Say, "you should be over this by now," or "you have to forgive the perpetrators(s) so you can start to heal."	Touch without spoken permission
Talk about your own trauma… keep the focus on the survivor.	Ask survivor to tell you about the traumatic incident(s)