Trauma-Informed Care: Past wounds, present problems

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Trauma-informed care has become a necessary part of chaplaincy

By David Lichter
Executive Director

This issue of Vision is devoted to spiritual care and trauma-informed care. We have seen “trauma-informed care” discussed in so many places over the past couple of years. We have all ministered in and reflected on the multiple environmental, health, social, and economic realities that cause trauma. None of us has been a stranger to some form of trauma in recent times.

You can recite the litany with me, yes? Dual pandemics of virus and racism, fallouts of natural disasters, economic hardships, deep political and social divides leading to violence of many kinds, and many other losses. Some days it’s living in layered levels and dimensions of trauma. It’s more “Which one today is causing my unease, sadness, and unsettledness?”

Over these recent years, I have needed to educate myself more on trauma. We were all taught that the most common type of trauma is from physical injury, but now we realize the list of sources is long: community violence; sexual, physical, and emotional abuse; disasters; early childhood and bullying; systemic and generational trauma. I have come to learn about acute, chronic, and complex trauma, and the types of responses we use, such as fight, flight, freeze, and fawn.

It has been very helpful to learn about the five general principles of trauma-informed care: safety; trustworthiness and transparency; peer support and mutual self-help; collaboration and mutuality; and empowerment voice and choice.

The 2016 white paper, “Key Ingredients for Successful Trauma-Informed Care Implementation,” by Christopher Menschner and Alexandra Maul,¹ was most instructive. The paper, available through the Substance Abuse and Mental Health Services Administration website, states, “Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”

Trauma now is often defined to also include the systemic cultural, historical, and gender issues within which individuals suffer for generations. Thus, trauma-informed care, while tending to individuals, must also address the stereotypes and biases that have caused and perpetuated historical trauma. How do we develop appropriate ministerial responses?

Two books have helped me look more closely at these social contexts. One is Spiritual Care in an Age of #Blacklivesmatter, edited by Danielle J. Buhuro. Published in 2019, its articles were written after the 2014 fatal shooting of Michael Brown in Ferguson, Mo., and the birth of the #Blacklivesmatter movement. Several authors are CPE educators. It is a thought-provoking, challenging, and critical read. It’s very helpful for understanding the broader social, cultural, and historical context of trauma from systemic racism.
The other book was *Injustice and the Care of Souls: Taking Oppression Seriously in Pastoral Care* by Sheryl A. Kujawa-Holbrook and Karen B. Montagno. Now a dozen years old, this invaluable collection of marginalized people’s voices examines the myriad experiences of those who have endured some form of oppression from society and church – sexism, racism, ageism, ableism, classism, or others. The authors challenged me to think differently about ministry to others whom I often don’t understand, and to appreciate the larger context that deeply affects their trauma.

Finally, I appreciated very much the workshop that David Hottinger gave at the APC’s recent virtual conference: *From “What’s Wrong with You” to “What’s Happened to You?” Reframing Spiritual Care through a Trauma Informed Lens.*² David, the manager of the spiritual care department at Hennepin Healthcare System in Minneapolis, introduced the participants to Dr. Sandra Bloom’s *Creating Presence,*³ an online resource to help become trauma-informed, responsive, and resilient. Take a look to discover how Presence is an acronym for … !

I appreciated the way David shared his own journey of powerlessness in the face of other people’s trauma, and his frustration with the individualized spiritual and psychological models of care in which he had been trained. Acute and complex trauma, he said, can be expanded to intergenerational trauma that is passed on over decades. Historical trauma is when specific groups of people experience emotional and mental wounding for generations. Finally, system-induced trauma is when trauma victims become trauma inflictors or become retraumatized via unjust policies, harmful practices, or racial/cultural bias. His PowerPoint presents a redeeming story worth reviewing both for his specific context and the resources he shared.

Please take time to read the articles in this issue of Vision. Trauma-informed care responds to a very complex, interconnected web of traumas. This is a personal and communal journey we are all on together as we seek to continue the healing ministry of Jesus in the name of the Church.

References
2 slidetodoc.com/from-whats-wrong-with-you-to-whats-happened/
3 www.creatingpresence.net
Trauma recovery center creates safe environment for patients

By OraLee Macklenar

Mercy Health Toledo Trauma Recovery Center opened in 2019 with the goal of providing a trauma-informed approach to behavioral health services.

Trauma-informed care seeks to prevent retraumatizing individuals who already have histories of trauma. The Substance Abuse and Mental Health Services Administration describes the three key elements as “(1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice.”¹

It takes awareness and a proactive stance to deliver genuine trauma-informed care. Our team (clinical case manager, victim advocate, and trauma-certified clinical therapists) work hard to deliver trauma-specific services. Our treatment strategies are evidence-based, which ensures that we are helping our patients with proven techniques for their recovery from trauma.

At the Trauma Recovery Center, located within Mercy St. Vincent Medical Center in Toledo, we work daily with individuals who have experienced some pretty horrific situations. We have helped many victims deal with the trauma from crimes such as assault, robbery, gun violence, gang violence, sexual assault, survivors of homicide victims, or human trafficking. Other patients are not victims of crime but are seeking outpatient, ongoing therapy for other traumatic life experiences. We provide clinical case management services, victim advocacy, and psychological therapy.

Our entire team has frequent training in TIC. We also attempt to work collaboratively with community agencies that are trauma-informed. In addition, many of us are active members on boards or coalitions that follow trauma-informed guidelines.

Many of our patients have a significant history of multiple traumatic experiences, referred to as complex trauma. Oftentimes, those with complex trauma have not experienced a warm welcome in other healthcare settings. Their past intense physical and psychological stress reactions may produce hypervigilance or a sensitivity that healthcare providers might not be aware of. The stress reactions can permanently harm the individual’s physical, social, emotional, or spiritual well-being.

As a result, we have taken practical steps to create a safe environment for our patients and their families. From our waiting room to our group room and our offices, we strive to make our patients feel welcome, safe, and comfortable. In addition, our team practices a very non-judgmental approach to individuals. We recognize that some patients’ personality challenges result from unresolved trauma. We also work from a strengths-based perspective. Helping traumatized individuals recognize that they have great value is the beginning of the healing journey. This is where hope begins for many. To be believed in, recognized, and listened to are some of the basic human needs that our patients are seeking.

¹ Found at store.samhsa.gov/sites/default/files/d7/priv/sma15-4420.pdf
We collaborate with patients in setting treatment goals. Keeping patients actively engaged in their treatment assists in successful trauma-informed care. In addition, we complete trauma scales, measuring pre- and post-treatment outcomes.

Our mission is to reach out to the members of our community who have suffered from violence, trauma, and loss. Our team is dedicated to serving the community by promoting healing with respect, compassion, and effective mental health services.

OraLee Macklenar, LISW-S, is a supervisor at Mercy Health Toledo Trauma Recovery Center.
Trauma-informed care: Another tool for chaplains’ box

By Raymond Dougherty

While I was familiar with trauma-informed care in the past, I found it became much more important to my practice after the 2017 firestorms in Sonoma County.

Hundreds of our healthcare providers and patients lost everything that year. Our hospital was evacuated in the dark of the night and remained closed for 17 days as the fires raged on. In the end, 5,643 structures, half of which were homes in Santa Rosa, were destroyed, and 22 people died. The whole community endured persistent toxic smoke, rolling power outages, evacuations, and the daily fears of the raging firestorm.

“Tell me more” is a common spiritual care phrase. For those experiencing trauma, however, this process of sharing their story could lead to re-traumatization. I witnessed tense body language, panicked speech, heightened vigilance, and rapid breathing of those who began recalling their harrowing escape from their burning homes. I realized then that I needed to be more aware of how my well-intentioned interventions impacted those in trauma.

I began learning new techniques to calm the nervous system and begin the healing process — for myself and those I served. It has been a journey into a vast, burgeoning field of care that helped me recognize and respond to trauma in an informed way.

A trauma-informed approach is guided by four assumptions, known as the “Four R’s”:

1. **Realization about trauma** and how it can affect people and groups,
2. **Recognizing the signs of trauma**,
3. **Responding** by integrating knowledge about trauma into our practice, and
4. **Resisting re-traumatization**.

I am not an expert on trauma-informed care, but just keeping these “Four R’s” in the forefront can help all of us be more aware of trauma in ourselves and others and take some steps to address it.

One model that has helped me, developed by Dan Siegel, MD, is the “window of tolerance.” This has been especially helpful for the medical staff who are dealing with trauma on a regular basis and/or experiencing secondary or vicarious trauma.

When we are handling the inevitable ups and downs of life, we are within our window of tolerance. However, if we move outside of our window, we can become either hyper-aroused or hypo-aroused. When my nervous system is hyper-aroused, I might notice that I’m more defensive – or blaming and judging others (or myself) more harshly. Maybe my mind is racing, or I can’t sleep. I might be more, angry, anxious, or panicky. Or in hypo-arousal, I might be more apathetic, checked-out, disconnected or dissociating, sluggish, burned out, and have weaker boundaries.
Does any of this ring a bell? These common responses to leaving our “window of tolerance” help us deal with unwelcome sensations, but often create problems if left unattended. This is where we as chaplains come in. We can develop and promote healthy, nurturing strategies to help restore the body to a more regulated place.

In a trauma-informed practice, this process is called resourcing. Resourcing works to help calm the nervous system and restore a sense of calm, peace and safety in the body, bringing our nervous systems down from a state of hyper-arousal or lifting the fog of hypo-arousal. Many examples are familiar to chaplains, such as prayer and meditation, breathing practices, pet therapy, shaking or dancing, taking a mindful walk, exercise and engaging the senses through music, aroma therapy, or focusing on something beautiful, etc.

So, to go back to the “tell me more” scenario: Rather than repeating the traumatic story, a trauma-informed response might be to “pendulate” between the story and the safety of the present moment in the body. Because trauma is stored in the body, trauma-informed interventions frequently incorporate somatic expressions and interventions.

So, in good old CPE fashion, try it out for yourself:

1. Imagine something that distresses you (nothing too intense for this exercise – maybe a 4 or 5 on a scale of 10, slightly outside of your “window of tolerance”). Rather than focusing on the story of the distress, start by noticing the “felt sense” of your distress – in your body. Where do you feel the distress? What does it feel like? Take a moment and experience the sensations. If you become overwhelmed by focusing on the distress directly, bring your attention out to just the edges of it.

2. Now scan your body for a place that feels calm. Maybe in your hands or feet, maybe just your pinky toe – some place in the body that is free from the distress. Or try bringing to mind a pleasant memory and notice how your body feels as you recall that memory. What does that feel like? Rest in that calm for a moment, really giving yourself time to experience it, to savor it.

3. Pendulation is the act of shifting your attention between these two experiences in your body. From distress to safety or calm, slowly touching in on the distress but in a way that is safe and healing. Be present for the feelings of distress for just as long as is tolerable, and then shift your attention back to the part of your body where you found peace or calm. Slowly shift back and forth and notice how the distress changes or perhaps becomes more tolerable.

Another good resourcing technique we introduced to the staff is the Self-Compassion Break, developed by Kristen Neff. It, too, starts with locating the stress or emotional discomfort in the body. The next step is to mindfully acknowledge that this is a moment of suffering. You might say to yourself “this hurts” or “this is what stress feels like.” Next, say to yourself something like, “this suffering is part of being human” or “other people feel this way too.” This moves us from a sense of isolation to acknowledging our common humanity. And finally, put your hands on your heart (or belly or wherever you are feeling your distress) and extend kindness and compassion to yourself as you would a good friend in the same distress. Using this myself, and introducing it to stressed-out
staff, has been a great way to introduce a form of resourcing that is easily incorporated into our day-to-day work flow.

Most of our patients are experiencing some form of trauma and distress, and many of us carry some measure of trauma or vicarious trauma in our bodies. The spiritual care interventions we provide every day can be even more profoundly healing when we provide them in a more trauma-informed manner. Trauma-informed care is a vast and fascinating field that I hope you will consider learning more about and adding to your “chaplain tool box.”

Raymond Dougherty is director of spiritual care services at Kaiser Permanente Marin/Sonoma in California.

Reference

Trauma-Informed Care Resources

Books
Waking the Tiger: Healing Trauma by Peter A. Levine

The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma by Bessel van der Kolk M.D

My Grandmother’s Hands: Racialized Trauma and the Pathway to Mending Our Hearts and Bodies by Resmaa Menakem, www.resmaa.com/about

Self-Compassion: The Proven Power of Being Kind to Yourself by Dr. Kristin Neff, self-compassion.org/self-compassion-kristin-neff

Podcasts

On Being: Krista Tippett with guest Resmaa Menakem ‘Notice the Rage; Notice the Silence,’ onbeing.org/programs/resmaa-menakem-notice-the-rage-notice-the-silence

Other resources
Traumahealing.org (includes list of Somatic Experiencing Practitioners)

Self-Compassion.org
Police chaplain delivers trauma care in the places where it’s needed

By Mike Corrigan

“Trauma care outside the trauma setting” is how I sometimes describe my work as a chaplain with the Wichita Police Department. However, delivering trauma-informed care is very difficult in these situations.

After my board certification, I worked as a staff chaplain in a Level One trauma center hospital. In trauma care, the patient is very often incapable of communicating, and I focus on family and friends of the trauma patient. These trauma cases are almost always unexpected because of auto collisions, shootings, falls, and various other incidents. Loved ones are usually upset, distressed, and not thinking and acting rationally. Once in a while I followed up in-house with some of the trauma victims, but usually that was the job of the ICU chaplain, while normally I would have one or two additional visits with their families.

Five years ago, I retired from the hospital. But I wanted to continue working part time, and I found my place in hospice care. I found many differences and similarities between trauma care and hospice care. I continued to use empathetic care with patients as they entered the final stage of their lives and with family members as they prepared for the death of loved ones. However, these cases are very seldom unexpected. I am often involved with patients and families for weeks or sometimes many months. In these less stressful situations, I am usually able to help the patients and families discover for themselves how to find meaning, purpose and comfort in the impending death.

While I have earned my living in both the hospital and hospice settings, I also volunteer as a police chaplain with the Wichita Police Department. Police chaplaincy tends to mirror the trauma situations in the hospital, but without the medical staff, physical comfort of the hospital building, or often access to simple amenities such as water or restrooms.

Like the trauma department, the police calls that I respond to are always critical situations. Most involve death. As in the trauma center, they are unexpected and very often young victims. Also like the trauma bay, I have limited time with the patients and their families. Rarely do I have any contact after the call. I might spend two or three hours with them and maybe attempt to help them find follow-up support, but I am then out of the picture.

Hospitals try to create comforting settings in our quiet rooms and safety areas for family members of victims to feel safe and comfortable. But a police call is often at the crime scene, and the family of the victim has to deal with weather, other people, and uncomfortable situations as they face one of the worst moments of their lives.
In Wichita, police chaplains almost exclusively support the victims and their families. This does differ from chaplains I know in other departments, some of whom focus on supporting the police officers and staff. On our local chaplain volunteer team, some of us are board-certified chaplains. Others are ordained Protestant ministers, including some who have learned chaplaincy by a pseudo-verbatim process. After a call, they often go through the encounter on a step-by-step basis with peer chaplains and learn from the responses of those that they have cared for.

I find great meaning in both hospice and emergency hospital work. But on a police call, where often the families and victims have many life issues and difficulties even before the unthinkable emergency, I have found my work to be most meaningful of all.

*Mike Corrigan, BCC, is a staff chaplain with Phoenix Hospice in Wichita, KS, and a volunteer chaplain with the Wichita Police Department.*
Research offers clues for delivering trauma-informed care

By Austine Duru

Trauma can have lasting impact on its victims and those who care for them. The presence of chaplains in those situations can be integral in supporting patients, families, and staff through traumatic events. This article examines current research literature on this topic, which may hold valuable lessons for chaplains and educators.

Rambo, S., Wiinikka-Lydon, J., Okafor, J., (2020), Trauma and moral injury: A guiding framework for chaplains.¹ This ebook introduces readers to the phenomena of trauma and moral injury. It goes into some detail about the sources of trauma and moral injury, and how these show up in individuals. The authors methodically guide chaplains to identify trauma and moral injury in their ministry and ways to effectively support and care for individuals experiencing trauma. This free ebook was recently updated to include recent COVID-19 trauma and the wounds of racial trauma that have resurfaced.

Pater, R., Visser, A., & Smeets, W., (2021), A beacon in the storm: Competencies of healthcare chaplains in the accident and emergency department.² This article investigates the experiences of chaplains in the emergency department and trauma units and explores the competencies that help chaplains become more effective in these high-paced settings. The authors interviewed chaplains and nurses across nine hospitals, and they concluded that chaplains who work primarily in the emergency and trauma spaces will need 10 primary skills. These include “psychosocial and communicative skills, knowledge of mourning processes, flexibility, sensitivity, and reflexivity. Additional competencies included sensitivity to existential concerns, practicing presence, a person-centered approach, medical knowledge, and letting go of a solution-oriented approach.” The authors also underscore the importance of self-care for those working in trauma settings.

Lewis-O’Connor, A., Warren, A., Lee, J., Levy-Carrick, N., Grossman, S., Chadwick, M., Stokes, H., & Rittenberg, E., (2019), The state of the science on trauma inquiry.³ The authors highlight the adverse impact of patients’ trauma and the significant role that healthcare providers play in addressing it – although they say that current inquiries about trauma are limited. They identify principles of trauma-informed care as an important framework for effective intervention, with a focus on resilience. The authors propose best practices, including “tiered screening starting with broad trauma inquiry, proceeding to risk and safety assessment as indicated, and ending with connection to interventions.” The article is aimed at clinicians, but some of the lessons can benefit chaplains and chaplain educators. The description of the three levels of trauma (individual, interpersonal, and collective) is a reminder that trauma is pervasive and requires an interdisciplinary and multi-pronged approach. This article provides a good introduction to the concept of trauma-informed care and might be a good tool for chaplaincy training and CPE programs.

Jobe, J., Gillespie, G., Schwytzer, D., (2021), A national survey of secondary traumatic stress and work productivity of emergency nurses following traumatic patient care.⁴ This research study investigates the correlation between secondary traumatic stress and productivity level of nurses
in a dynamic emergency department that cares for trauma patients. Secondary traumatic stress has been described as a “normal reaction to abnormal event” (Figley, 1995). The findings suggest a positive correlation between secondary traumatic stress and lower work productivity for nurses who work in trauma patient care. The study confirms what was already common knowledge among healthcare workers, including administrators and chaplains. The authors propose several remedies, including stress reduction and management techniques, self-initiated social support, and self-care programs. This study has similar implications for chaplains who work alongside nurses in trauma patient care settings.

Gomez, S., White, B., Browning, J., & DeLisser, H., (2020), Medical students’ experience in a trauma chaplain shadowing program: A mixed method analysis.⁵ This article studies medical students who shadow chaplains working in trauma situations. The program attempts to reclaim the holistic dimension of medical education by incorporating pedagogic element of spiritual care into the curriculum (Puchalski, Blatt, Kogan, et al., 2014). The study aims to enhance the knowledge and awareness of “(i) the role of chaplains/pastoral care in patient care; (ii) strategies for engaging patients and/or families in difficult situations; and (iii) approaches for discussing issues of spirituality with patients and families.” The data, collected from 148 medical students over six years at the Perelman School of Medicine at the University of Pennsylvania, indicates that shadowing a trauma chaplain has significant benefit for medical students. This knowledge will benefit educators and/or chaplaincy programs within academic medical centers, or centers with medical residency programs.

Ashana, D., Lewis, C., & Hart, J., (2020), Dealing with “difficult” patients and families: Making a case for trauma-informed care in the intensive care unit.⁶ This article establishes that trauma often disproportionately affects low-income minority populations, who develop ways for coping with all kinds of trauma. When these learned adaptive behaviors manifest in the healthcare environment, families or patients are sometimes labelled as “difficult” by healthcare staff. This inevitably results in re-traumatization and medical trauma. The authors argue that trauma-informed care can minimize re-traumatization by seeking to recognize and understand these adaptive mechanisms in the acute care settings. This is a helpful tool for chaplains, who are often uniquely positioned to intervene in these situations to advocate for patients and families and invite dialogue to uncover prior experience of trauma.

Austine Duru, BCC, is vice president of mission with Bon Secours Mercy Health in Ohio.

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‘What happened to you?’ is the key question after a trauma

By Fr. Ragan Shriver

A few years ago, a treadmill accident left me with a broken foot. For the next eight weeks I walked around with a boot. During this time no one asked me, “What is wrong with you?” Instead, I was asked, “What happened to you?” The difference between these two questions, though subtle, defines the core of trauma-informed care: a human person is not equated with a problem or illness he or she is experiencing.

My broken foot was the result of a traumatic injury that impacted my behavior (how I walked), my attitude (frustrated due to the pain) and my recreational life (no jogging). In other words, my life had been altered by the injury, but my whole being was not called into question.

Unfortunately, this is often not the case when people seek support in a behavioral health setting. Instead, they often face questions about their being rather than receiving treatment for the specific injury, which may be some other type of trauma like abuse, violence, or disaster. Yet, the scar of this trauma impacts a person’s behavior, attitude, and life, just like my broken foot did. Emotional trauma can result in anxiety, depression, addiction, or other behavioral/social difficulties. The trauma-informed approach seeks healing for the injury, and it avoids defining a person based on the impacts from the injury.

This approach grew out of the Adverse Childhood Experiences study (ACE) and subsequent research, which were developed after Kaiser Permanente’s research arm studied obesity treatment. Many of the subjects in the Kaiser Permanente study who had reduced their weight regained it. In follow-up interviews, they said that they needed the weight to feel safe or that eating numbed negative feelings. When questioned further, almost 75 percent of the subjects described a history of trauma. Kaiser then partnered with the Centers for Disease Control and Prevention in the ACE study to investigate the impact of childhood trauma on the lives of 17,000 persons enrolled in Kaiser’s insurance plan. The result showed that 64 percent of the subjects had experienced at least one adverse experience in the years prior to age 18.

In subsequent research, more work was done to identify how trauma impacts people’s lives. A chain reaction to trauma was identified that indicates the likelihood of early death for victims. The chain begins with a painful event leading to negative emotions and self-appraisal, resulting in maladaptive behaviors that temporarily curb negative feelings and numb the low self-esteem. But these behaviors, such as smoking, overeating, use of substances, and non-suicidal self-injury, yield poor health outcomes. People with a trauma history are four times more likely to have substance use disorders than the general population, leading to such conditions as asthma, diabetes, obesity, and overdose, which may result in early death. The conclusion is that trauma is a significant factor leading to a serious public health concern.

In the years since the original research, further study and practice have better equipped service providers to support survivors seeking recovery from adverse childhood experiences or other traumas. Interventions are founded on a clear definition of trauma. Basically, trauma is something
that overwhelms a person’s internal systems, thus compromising the ability to cope. An analogy might be a city that is hit with a flood. The water disposal system cannot handle the extra rain, causing flooding and erosion in the short term and mold or rust in the long run. The system has been overwhelmed and will need external support to recover. In the same way when an individual experiences trauma the physiological reaction can overwhelm the typical stress response system, bringing about anxiety or depression leading to maladaptive patterns of behavior and long-term negative health outcomes.

Many ministers who serve people interacting with the justice system have begun using trauma-informed care for their clients. It means providing universal screening for trauma in clients’ histories, creating physical environments that convey safety and comfort, engaging in therapeutic interventions that deal directly with the experience of adversity, and creating positive alternatives to destructive coping strategies.

One very important component is a positive, healing relationship between a minister and the person being served. However, many victims of past trauma have difficulty trusting others. Aware of this, ministers express a desire to be trusted by the person and ask if they can create such an environment together. This type of approach gives an element of control to the client, creating an empowering partnership that can lead to healing.

But along with the people being ministered to, ministers themselves also need to also be cared for sensitively. This is due to the possibility of vicarious trauma. Hearing others speak of atrocities that have happened in their lives can take a serious toll on providers, leading to emotional and behavioral reactions just as those who primarily experienced trauma. Hopefully, all ministers seek quality supervision based in trauma-sensitive theory, outlets for stress relief, and collegiality with others.

Trauma-informed ministry may seem like a recent development, but we can look to the important role that Jesus played in meeting people where they were, accepting people, allowing those he encountered to know of the Father’s unconditional love for them, and empowering his followers. Our services are truly grounded in our savior, the truest healer of trauma, Christ Jesus.

Fr. Ragan Shriver is the director of social work program at the University of Tennessee.