



UNIVERSITY OF SAN FRANCISCO

CHANGE THE WORLD FROM HERE

The Personal is the Professional

Applying the Trauma-Informed Approach to Nonprofit Staff

by

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Abstract

The trauma-informed approach (TIA), in which organizations strive to modify their services to reflect the widespread and profound impact of trauma on the communities they serve, has made great inroads in the nonprofit sector. However, existing research suggests nonprofit leaders too often leave staff wellness out of the TIA equation, even as staff exposure to trauma leads to burnout and low retention. For this project, I conducted semi-structured interviews with six nonprofit leaders to learn more about how they did, and did not, incorporate staff wellness into their thinking as they strove to make their organizations more trauma-informed. I also interviewed two academic experts in the subject. Common themes that emerged included: understanding trauma through a communal as well as individual lens; the challenge of prioritizing staff wellness in the context of high workloads with major import for clients' lives; the difficulty of finding time and funding for trauma-informed training; the importance of TIA to providing a supportive workplace for staff of color in particular; the role of staff-led efforts to advance TIA; and finally, the importance of treating TIA efforts as a slow and evolving process that requires great patience.

Keywords: trauma, trauma-informed approach, trauma-informed care, secondary trauma, staff wellness, nonprofits, work culture

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Section 1. Introduction

The trauma-informed approach (TIA), in which organizations modify their services to reflect the widespread and profound impact of trauma on the individuals they serve, has made great inroads in the nonprofit sector. Once confined to the fields of medicine and youth services, TIA is an increasingly mainstream topic in the nonprofit sector as a whole (H. Pinderhughes, personal communication, March 9, 2021). It is now possible to find models for implementing TIA created by federal agencies (*SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014), consortiums of nonprofits and local government agencies (Trauma-Informed Community Network, n.d.), and grassroots coalitions (*Center Community in Public Health: Recognizing Healing-Centered Community Practices as a Complement to Trauma-Informed Interventions and Services*, n.d.). To take just one broad measure of the concept's popularity, Google Trends searches for "trauma informed approach" and "trauma informed care" show interest in these related terms as nonexistent in 2007, starting up around 2008, and roughly tripling between 2014 and 2019 (*Google Trends*, 2021a; *Google Trends*, 2021b).

However, research suggests nonprofit leaders too often leave staff wellness out of the TIA equation, even as staff exposure to trauma (sometimes called, secondary or vicarious trauma) leads to burnout and low retention. Most guides agree that *empowerment* is a key tenet of TIA, yet many leaders may be slow to understand empowerment as applying to staff, rather than exclusively to clients. One research team found that nonprofit leaders had plenty to say about the changes they were making to better provide trauma-informed services for their clients,

but when asked about improvements made with their staffs in mind, “met this question with a blank state and no concrete answers” (Wolf et al., 2014, p. 118).

For this project, I conducted semi-structured interviews with six nonprofit leaders to learn more about how they did, and did not, incorporate staff wellness into their thinking as they strove to make their organizations more trauma-informed. I also interviewed two academic experts in the subject. Three major themes emerged in the course of my interviews: first, the intersection of racism, diversity, equity, and inclusion (DEI), and community; second, the way TIA potentially brings professional personal identities into conflict; and finally, some practical solutions the interviewees have found to the question of how TIA can be implemented to the benefit of nonprofit employees.

This research study was conducted in the context of the COVID-19 pandemic. My interviews began in March 2021, right around the first anniversary of most nonprofits in California shifting offices to work-from-home setups. The pandemic is of course a major traumatic event for people worldwide, including everyone in my study. My interviewees mentioned it as a source of stress for their employees. Nevertheless, I chose not to focus on the effects of COVID-19 on TIA implementation at nonprofits, for two reasons. First, the shift to working from home has touched organizations in countless ways, and I did not think I could thoroughly dig into the implications of work-from-home without taking up most of my interview time. And second, I suspect that the pandemic's implications for TIA implementation will take at least another year to become clear, when nonprofit leaders have had some time and space to reflect on them further.

Defining trauma and TIA

Definitions of trauma and TIA vary. I find the American Psychological Association's definition, "Trauma is an emotional response to a terrible event," to be a good starting point (*Trauma and Shock*, n.d.). The insight of TIA pioneers Harris and Falloot was to assume, initially in mental health settings, that trauma is present and to integrate appropriate treatment for trauma into all services, not just those for patients stating abuse as their reason for seeking help. The purpose of TIA is not only to treat trauma but to avoid re-traumatizing the patient (*Using Trauma Theory to Design Service Systems.*, 2001).

One key tenet of TIA is that trauma is widespread. A principal way this has been quantified is screening medical patients for adverse childhood experiences, or ACEs. ACEs are "potentially traumatic events that occur in childhood" and have been found to predict chronic health problems, mental illness, and substance abuse in adults (CDC, 2019). The Centers for Disease Control (2019) estimate that one in six adults have experienced four or more ACEs, and state that this number is higher for women and racial minorities. ACEs have been promoted as a framework for service providers and advocacy organizations to understand and measure trauma ("What Are ACEs?," 2021).

The terms *the trauma-informed approach* (or *approaches*) and *trauma-informed care* are used more or less interchangeably in the academic and professional literature. Because trauma-informed care tends to appear more in discussions of healthcare, and because *the trauma-informed approach* implies a broader scope beyond caring for patients or clients, I will use *the trauma-informed approach* or *TIA* throughout this paper, except when citing authors who use *trauma-informed care*.

Another question of terminology is how to refer to the trauma experienced service-providers, as opposed to that of clients. *Secondary trauma* is sometimes used interchangeably with *vicarious trauma* to describe “a set of observable reactions to working with people who have been traumatized [that] mirrors the symptoms of post-traumatic stress disorder” (Administration for Children and Families, n.d.). Some researchers though, such as Canizales (2021) use *secondary trauma* specifically to refer to symptoms experienced by service-providers who “themselves have previously suffered a traumatic event.” Still others question the value of a distinguishing between these subcategories of trauma: “Vicarious trauma—I hate that term, because I don’t think there’s anything vicarious about it,” Dr. Howard Pinderhughes told me in an interview (personal communication, March 9, 2021). As I will elaborate below, Dr. Pinderhughes’ research has focused on the communal nature of how trauma is experienced. Both Dr. Canizales and Dr. Pinderhughes, in interviews with me, stressed the importance of using language carefully and clearly when discussing trauma.

Section 2: Review of Literature

Background: What is the trauma-informed approach?

Much of the contemporary discourse on the trauma-informed approach began with Harris and Fallot (2001). Harris, a mental health researcher, and Fallot, a clinical psychologist, drew on their own experiences to call attention to the widespread nature of trauma and to develop a foundational set of principles for what they called trauma-informed care. Harris and Fallot write that mental health providers must recognize the widespread nature of trauma, as many of the patients they treat have suffered undisclosed abuse. Trauma-informed care assumes that trauma is present and integrates appropriate treatment into all mental health services, not just those for patients stating abuse as their reason for seeking treatment. The purpose of trauma-informed care is not only to treat trauma but to avoid re-traumatizing the patient. Harris and Fallot also introduced the five principles of trauma-informed care that are referred to by nearly all of the other works cited here. These are: safety, trustworthiness, choice, collaboration, and, as noted in the introduction, empowerment.

Perhaps the most important work for my research, after that of Harris and Fallot, is that of Bloom and Farragher, who together have authored a trilogy of books on identifying trauma and creating trauma-informed organizations to treat it. Bloom, a psychiatrist, began the trilogy as the solo author of *Creating Sanctuary: Toward the Evolution of Sane Societies* (1997). This book described Bloom's involvement in creating the Sanctuary Model, a hospital-based program for treating adults whose health conditions Bloom understood as rooted in trauma they experienced as children. Thirteen years later, Bloom and Farragher, a social worker and the leader of a New

York-area nonprofit providing clinical services for children, released *Destroying sanctuary: The crisis in human service delivery systems* (2010), detailing how systematic disinvestment in the United States' mental health safety net beginning in the 1980s has resulted in "human services [that] have gotten far too good at dehumanizing people" (Bloom & Farragher, 2013, p. 274).

All three of Bloom's books have been highly influential, but the work that most directly relates to my research is *Restoring sanctuary: A new operating System for Trauma-informed systems of care* (2013). *Restoring sanctuary* is a guide for leaders of human-service providers who want to transform their organizations into trauma-informed ones. It details how Bloom and Farragher worked together to revolutionize services at Andrus, Farragher's nonprofit in White Plains, New York. They relate the challenges they met and the strategies they developed to overcome them, which they went on to institutionalize in the Sanctuary Institute, their vehicle for spreading the trauma-informed gospel as consultants. Since 2015, the Sanctuary Institute has certified dozens of organizations as trauma-informed, a designation that "symbolizes an organization's commitment to providing a higher level of care, a trauma-sensitive environment for the people they serve and a better work environment for employees" (Sanctuary Institute, 2020).

As the above description of Sanctuary's certification implies, Bloom and Farragher believe that the trauma-informed approach must take into account the staff carrying out trauma-informed procedures just as much as it does the clients or patients who are receiving the services. They call not just for democracy but even "consensus" as managers and front-line staff-members work through their organizational barriers to change, including staffers' own emotional resistance to change (p. 271). Because "the changes we make in an effort to better manage

organizational stress can also induce stress”, the transformation to a trauma-informed organization “must closely mirror the process” of dealing with patients’ trauma: exposing people a little bit at a time, and never rushing the process (p. 279). Leaders must be the face of the trauma-informed implementation process and model the new culture they want staffers to emulate, but even then, Bloom and Farragher find that it is natural for staffers to question the sincerity of leaders claiming to want a less hierarchical way of doing things, if not actively oppose the shift: “They look for evidence that contradicts what the leader is telling them”, and this “skepticism ... is quickly followed by a frenzied effort to get leaders to behave the way they always have done” (p. 285-6). Even in the best-case scenario, then, becoming trauma-informed is a slow and messy process.

As mentioned above, one challenge in the trauma-informed discourse is defining our terms, especially as discussion of the trauma-informed approach expands well beyond its start in the field of mental health. How can we even know if two organizations talking about implementing the trauma-informed approach are discussing the same thing? The Substance Abuse and Mental Health Services Administration’s (SAMHSA) 2014 report is an attempt to solve this problem. Given how often it was cited by other authors in my review of the literature, it appears to have succeeded.

SAMHSA is a federal agency under the auspices of the United States Department of Health and Human Services. The report defines individual trauma as resulting 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” (*SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, p. 7, emphasis in original).

The agency goes on to spell out four key “assumptions and principles” of the trauma-informed approach, which it calls “the four ‘R’s’”: a trauma-informed program

realizes the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re-traumatization**” (*SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, p. 9, emphasis in original).

It also adds two additional principles to the five originally put forth by Harris and Falot. One is “peer support”, which refers in this case to connecting survivors of trauma with each other to provide “mutual self-help” (p. 11). The other principle SAMHSA contributes is “cultural, historical, and gender issues”, by which it means “actively mov[ing] past cultural stereotypes and biases”, utilizing the “healing value of traditional cultural connections”, and “recogniz[ing] and address[ing] historical trauma” (p. 11).

SAMHSA’s guide does not simply provide definitions but also advocates for the widespread adoption of the trauma-informed approach. It calls for the trauma-informed approach to be taken up not only in mental health settings but in the “justice, education, and primary care sectors” as well (p. 6). Though published by a federal agency, it is written in approachable language and a humane tone, as in its assertion that “healing happens in relationships and in the meaningful sharing of power and decision-making” (p. 11).

Trauma as a communal phenomenon

Initially, most work on trauma and the trauma-informed approach took an individualistic approach, focusing on individual patients' experience of harm and tools that might treat it. One encouraging trend in recent literature on the trauma-informed approach is a shift towards seeing trauma as more than an individual experience; rather, it is something caused by unjust structures such as mass incarceration and racial segregation, and experienced by entire communities. Nonprofit service providers, likewise, do not just serve individuals; they operate inside of communities, and often their staffers come from those same, or similar, communities. Therefore, a communal/structural lens on trauma could help create a trauma-informed approach that does a better job of taking service providers into account. This trend is visible at the empirical level: Champine et al (2019) reviewed hundreds of existing scales for measuring TIA implementation in organizations published between 1998 and 2018, ultimately identifying 49 unique measures. Categorizing these measures as relational, organizational, or community- or system-focused, they found a trend in recent years away from a focus on individual trauma and towards a communal or structural understanding, which they see as a positive development.

Pinderhughes et al (2015), in a report published by the Prevention Institute, argue in contrast that violence inflicts trauma at the communal level. When acts of violence occur in "high-violence communities," these incidents impact not only the people physically wounded and the immediate witnesses to the crime, but also "service providers, first responders and residents" (p. 8). In particular, despite some advances in thinking about community-level *treatment* for trauma, "there is not yet a framework for *addressing* and *preventing* it" as such (p.

4, emphasis mine). The authors suggest improvements to the “social-cultural environment” and “physical/built environment” as well as “improve[d] economic opportunities” (p. 6). It is “critical”, they write, “that attention go beyond individuals and beyond a focus solely on treatment and protocols after exposure to traumatic conditions” (p. 6).

Pinderhughes et al indicate that understanding trauma’s roots in structural causes also means understanding the need for policy-level solutions. In “Trauma-Informed Social Policy: A Conceptual Framework for Policy Analysis and Advocacy” (2016), Bowen and Murshid posit a framework for applying a trauma-informed lens to social policy advocacy. Following the philosophy of *health in all policies* and recognizing trauma’s disproportionate impact on marginalized communities, the authors urge policymaker and advocate incorporating the trauma-informed principle of empowerment into their work. “Empowerment in social policy”, they argue, must “reflect not only a rhetoric of liberation but actual shared power in terms of extending decision-making ability to the target populations of social policies” (p. 226).

Bowen and Murshid cite the AIDS activist group ACT-UP and its collaboration with federal healthcare policymaker as a successful example of this dynamic. All policies “should aim to address disparities ... a close to the root as possible,” they write (p. 227). The notion of empowerment is always a tricky one, open as it is to interpretation. (C.f. Wolf et al, 2014, in which a clinician attempts to spin a lack of support for staffers as a way of empowering them.) The specific example of ACT-UP makes the idea of engaging marginalized communities in trauma-informed policymaking more concrete.

As Bowen and Murshid argue for bringing the trauma-informed approach into politics, so do McKenzie et al (2012) advocate bringing politics into the trauma-informed approach. Writing

about therapeutic interventions for homeless youth, they call for going “beyond a focus on individual symptoms and recovery to ... the eradication of societal contributors to this problem” (p. 136). The current model of the trauma-informed approach, they state, lacks adequate political and social analysis to be fully effective. They call instead for “a radicalized notion of trauma”, one that draws “upon a broadened and contextualized lens to explore distress, the daily experiences of living in a classist, racist, patriarchal and heterosexist society” (p. 136).

The movement towards a structural understanding of trauma exists outside of the United States as well. Bateman et al (2014) propose a national strategy for Australia of widely implementing the trauma-informed approach by integrating it into policymaking and service-provision. The current systems, their paper finds, are failing to effectively deal with trauma by ignoring the links between trauma and mental and physical health outcomes. Trauma “must be seen as the expectation, not the exception” in all service contexts (p. 5), the authors write. To effectively address trauma and its related problems on a societal level, the government and nonprofit sector need an aligned understanding of the trauma-informed approach that can suffuse service provision and policymaking at every level. Above all, this approach must be “holistic,” comprehending the links between trauma, mental health, and physical health, rather than treating them as distinct areas of concern (p. 4).

Taking a wide-lens view of trauma, however, does not just mean engaging the state in solutions. It also means traumatized people themselves leading the way in healing their communities. The Praxis Project’s report, *Center Community in Public Health: Recognizing Healing-Centered Community Practices as a Complement to Trauma-Informed Interventions and Services*, is the result of a 2018 conference in Milwaukee that brought together 55 grassroots

(or “base-building”) community partners from across the country to better understand the concepts of communal trauma and to share tools for communal healing. The report seeks to put at the center of the trauma-informed discourse what Pinderhughes et al, above, have called “indigenous knowledge”: marginalized communities’ “healing-centered practices,” developed over time to combat the “structural causes” of trauma and help communities repair themselves (p. 1). Healing practices range from the overtly political (boycotts, advocacy, combating capitalism) to the personal (taking walks, cooking, dancing) (p. 4-6).

The trauma-informed approach and staff wellness

This capstone project sprouted from two seeds. The first, years ago, was reading Lipsky and Burk’s 2009 book, *Trauma Stewardship*. Lipsky was a service provider whose experience of in nonprofit direct services led her to a point of emotional and psychological exhaustion: “After so many years of hearing stories of . . . those I was trying to help—in other words, of bearing witness to others’ suffering—I finally came to understand that my exposure to other people’s trauma had changed me on a fundamental level” (Lipsky & Burk, 2009, pp. 2–3).

The more recent seed of this capstone was a paper by Wolf et al, “‘We’re Civil Servants’: The Status of Trauma-Informed Care in the Community” (2014), for which the researchers used ten focus groups and six individual interviews with social service agency employees, from admin to management, to learn how nonprofit workers at different levels of authority saw their organizations’ implementation of the 5 principles of trauma-informed care (safety, trustworthiness, collaboration, empowerment, and choice). Wolf et al found that social service agencies pursuing trauma-informed care are focused on that approach’s benefits for

clients and understand its key principles, but “are unaware of the relevance of trauma-informed care as it relates to staff.” The authors recommend further research into whether trauma-informed care “prevents ‘burnout,’ high turnover rates, and vicarious traumatization of staff” (p. 111).

Wolf et al vividly capture the tension between staff and client interests in the pursuit of the trauma-informed approach. When asked about staff empowerment, some respondents displayed “prolonged silence and a lot of fidgeting and looking around” (p. 115) and “met this question with a blank state and no concrete answers” (p. 118). As referenced above, one respondent, a physician, gave an answer that seems meant to be positive but in fact exposes the absence of support: “I think you have to be pretty self-sufficient and in a way that’s empowering” (p. 118). The authors illuminate the inherent difficulty of doing right by both clients and staff in the context of a customer-service model; as one respondent tells them, “Everything’s supposed to be consumer choice”, but neither clients nor staffers truly have a range of options to choose from (p. 116).

One of Wolf’s co-authors, Nochajski, went on to co-author three more studies that attempted to find quantitative evidence of the trauma-informed approach’s effect on staff wellness. Kusmaul, Wilson, and Nochajski carried out a similar study in 2015. They had respondents fill out a digital survey with questions using a five-point Likert scale. The questions aimed to measure staff’s perception of the degree to which the trauma-informed approach was being implemented in their organizations. Eight questions asked about safety, six about trustworthiness, six about choice, six about collaboration, and eight about empowerment. They found that “[d]ifferent levels of staff”—i.e., administrative and front-line staff versus managers—“experience trauma-informed care implementation differently” (Kusmaul et al.,

2015, p. 25). Specifically, non-managerial staff and staff with lower levels of education (two groups that overlap greatly) were more skeptical of the trauma-informed approach than managers and those with more education, suggesting that lower-level employees may see trauma-informed care as something unwanted and imposed on them from above. However, all these findings are weakened by a poor response rate, many incomplete surveys, and a reliance on managers to distribute the survey to staffers.

Hales, Nochajski, et al (2017) found that agencies that have adopted trauma-informed care report greater staff satisfaction, as well as staff retention, commitment, and performance. The researchers issued two surveys to employees of non-profits operating in the areas of mental health and substance abuse, with 147 respondents to the first survey and 168 to the second. Employees ranged from admin to management and answered questions meant to ascertain the extent of their agencies' implementation of trauma-informed care as well as their own feelings of job satisfaction. Questions used a 5-point Likert scale. The findings that greater implementation of trauma-informed care correlated with greater staff satisfaction are heartening. Unfortunately, the researchers note that they used an external agency to collect data and did not have access to the raw data themselves, so they could not meaningfully disaggregate responses, nor match individual participants' responses from one survey to the next to see if they had changed their minds.

The most recent of these quantitative studies was a 2019 study from Hales, Nochajski, et al in which the researchers evaluated a multiyear trauma-informed care implementation process at a residential addiction treatment program. Respondents filled out surveys three times: before, during, and after the implementation of trauma-informed care. The number of respondents was

about 60 but varied with each instance of the survey. They asked staff to measure their satisfaction and their perception of the extent of trauma-informed care implementation (using Falloot and Harris's five principles). Clients were asked to measure their satisfaction with services. In addition, the researchers analyzed metrics of success such as client retention and the number of clients who stayed until their planned discharge dates.

Hales et al found significant improvements in client outcomes, overall staff satisfaction, and staff's perception of their organization as trauma-informed. However, certain measures of staff satisfaction (perceptions of being informed about changes in the agency and transparency around staff performance evaluation) declined significantly, and client perceptions of trust and rapport with staff declined slightly. Overall, the authors found meaningful evidence, making this the strongest quantitative study so far on the impacts of trauma-informed care implementation.

Three of the authors involved in the above quantitative studies, together with Sundborg, reviewed existing scales for measuring trauma-informed care implementation and found that they tend to be "industry specific" as well as long; one created in 2009 has 135 questions (Hales et al., 2019, p. 5). Two of the authors in 2015 created the Trauma-Informed Clinical Scale, a 34-question survey, but believed an even shorter survey could still be effective. This paper found that a ten-question survey yielded reliable information, providing an attractive option for researchers and managers to evaluate their staff's perception of trauma-informed care implementation.

The authors perceptively note that there are "many challenges to measuring trauma-informed care implementation", one of which is "a strength of trauma-informed care itself: trauma-informed care implementation looks different across organizations and settings because it

is able to adapt to specific needs and circumstances” (p. 4). That said, this reduced scale appears to offer an excellent tool for quickly measuring trauma-informed care in a given organization and may reduce incomplete surveys of the kind that marred Kusmaul et al’s 2015 study.

Damian et al (2018) add some interesting nuance to the question of how non-managerial nonprofit staffers see the trauma-informed approach. The authors studied a nine-month training for government and nonprofit service providers in Baltimore, put on by the National Center for Trauma-Informed Care. This was a mixed-methods, pre-post study, having participants fill out a survey before starting the trainings and taking the same survey again after finishing. In addition, a smaller number of participants gave semi-structured interviews following the trainings. The study found that significant improvements in participants’ self-reported knowledge of trauma-informed care and improved attitudes towards trauma survivors after participating in the training, but no change in their self-reported capacity to effectively provide referrals to trauma-informed services. Participants identified challenges to implementing trauma-informed care in their organizations: a lack of buy-in from upper management, difficulty connecting their new understanding of trauma to “real-life” practices, and a confusion over “next steps” (p. 5). It is surprising that participants reported a need for management to be more involved in the training process, given that Kusmaul et al (2015) found that managers tended to be more engaged with trauma-informed care implementation than the staffs they supervised. Participants’ lack of clarity about next steps following the training is frustrating, as so much literature now exists on concrete steps for transforming organizations into trauma-informed ones. This may reflect the lack of participation by managers in the trainings, as they may be the people most likely to believe they could implement new policies. The study is a reminder that, for successful implementation of the

trauma-informed approach, empowerment—one of Harris and Fallot’s original principles of trauma-informed care--cannot be understood to refer solely to clients.

In *Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation*, Bloom (n.d.) takes lessons from her field of training, psychiatry, in which changes beginning in the 1980s “have resulted in a significantly heightened level of individual and organizational stress” for programs serving patients with the greatest needs (p. 2). She concludes that all human service organizations would benefit from adopting the concept of “social learning” from psychiatry, which promotes “an environment where client and staff are learning from each other all the time” (p. 7). Organizations must be understood as “[l]iving systems” that are complex and dynamic, and therefore capable of being traumatized but also capable of learning and growing (p. 2).

Understanding the trauma of clients and staff as interrelated and functioning at an organizational level provides a way to talk about the trauma-informed approach and staff wellness in the same breath. Bloom’s warning that “A program cannot be safe for clients if it is unsafe for the staff and the administrators” is the perfect encapsulation of the argument that the trauma-informed approach must be seen as a tool for staff wellness if it is to successfully transform services for clients (p. 10). Furthermore, Bloom cautions that the trauma-informed approach cannot be implemented haphazardly or without specific intentionality: “A system cannot be trauma-informed unless the system can create and sustain a process of understanding itself” (p. 2). In the end, though, her assurance that organizations, like people, can heal from trauma and go forward stronger makes this a highly optimistic work.

Section 3: Methods and Approaches

This is a qualitative study, based on semi-structured interviews. Using convenience sampling, I drew on personal and professional connections to find interview subjects. I interviewed five nonprofit leaders. I defined a *leader* as anyone with managerial responsibilities; three of the interviewees held or previously held the title of executive director, while two held managerial responsibilities but were not in charge of their entire organizations. Two of the leaders were White¹ women, two were Black women, and one was an Asian man. Three of the leaders were trained as attorneys and worked in legal services, and the other two worked in youth and family services. For background research, I also interviewed two academic experts studying TIA, both of them professors at public universities in California. One expert was a Black male professor, decades into in his academic career, and the other was a Latina female professor, only a few years past her dissertation. (I have included details on my interviews in Appendix A, below.)

Interviews were semi-structured and lasted 45-75 minutes, depending on interviewees' availability. Using a semi-structured format allowed for long, nuanced answers to my questions, and made it possible to bring up subtopics in the later interviews that came up in the earlier interviews, such as the importance of staff's racial identity as a factor in creating a trauma-informed workplace.

¹ Note that throughout this work, I will capitalize the words *White* and *Black* when they refer to racial categories. The term *Black* has long been capitalized in certain circles as a sign of respect for the shared history and culture of African-descended people living in the United States. More recently, some writers and publication have begun capitalizing *White* as well, to recognize a recognition that whiteness is as much a sociologically constructed identity as blackness in this country (cf., WashPostPR, 2020)

Positionality statement

I am a 36-year-old, White man with a Bachelor's degree from a private liberal arts college. I have worked in the nonprofit sector for most of my adult life, usually in a direct-services role. I have not held a leadership position in a nonprofit organization. My interest in TIA in the nonprofit sector stems from my own experiences serving clients with traumatic backgrounds and experiencing what I would identify as secondary trauma in myself as a nonprofit employee. I should not that the East Bay Community Law Center (EBCLC), an organization from which I interviewed two leaders for this project (one former and one current), was my workplace from 2009 to 2012. The former director was my boss (though not my direct supervisor), and the current director worked with me as part of small team within the organization for about three months. I have not worked for any of the other organizations named in this project, nor have I worked with any of the other interviewees.

Section 4. Discussion of Findings

I have chosen to focus this analysis on the three most prominent and intersecting themes I identified, as named above in Section 1: first, the intersection of race, racism, DEI, and community; second, the way TIA potentially brings professional and personal identities into conflict; and finally, some practical solutions that interviewees have found to the question of how TIA can be implemented to benefit nonprofit employees.

Hiring “from the community”: how racism and DEI intersect with TIA

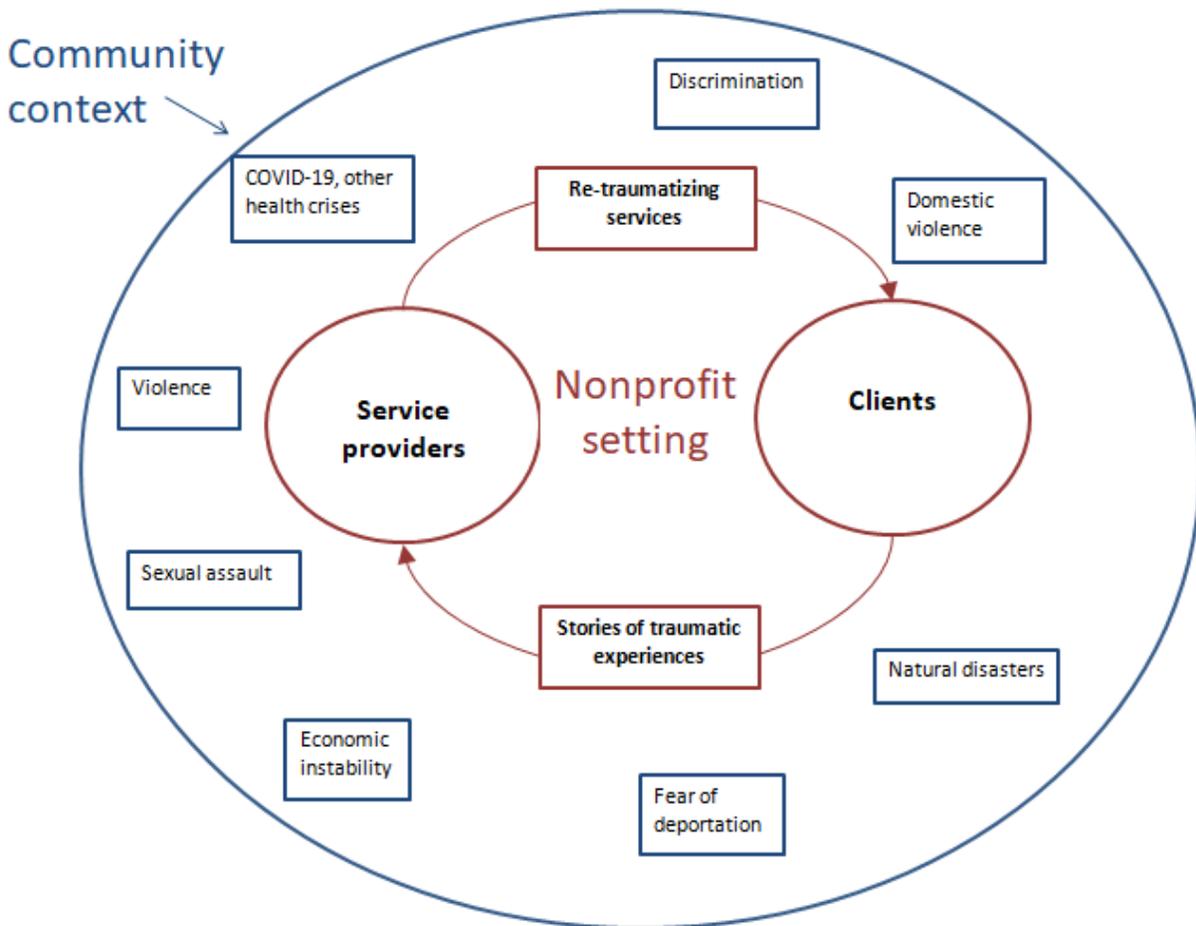
Communal trauma is client trauma is staff trauma

Diversity, equity, and inclusion, or DEI, has become a hot concept for corporate and nonprofit management in recent years. The heightened focus on racial justice in 2020 made the question of racial diversity particularly salient. Although I did not include any questions about race, racism, or DEI in my initial interview guide, these turned out to be significant topics in all of my interviews. There was a common desire across my five nonprofit leaders to hire and retain employees who came from the communities their organizations served, particularly Black and immigrant employees. Yet the interviewees also recognized that drawing from traumatized communities meant that employees brought that trauma with them into the workplace.

As discussed in the review of literature above, there has been increasing attention in the field of TIA studies to the communal nature of trauma. I believe one of the most important intellectual advances the nonprofit sector can make in implementing TIA is to do away with the false conception of staff, clients, and “the community” as three separate groups of people. Most

direct-service employees live in the same community as their clients to some degree, and this is especially true when organizations intentionally hire from the communities they serve (e.g., an organization that serves recently arrived immigrants hiring other recently arrived immigrants, or an organization in a mostly Black neighborhood hiring Black employees). Figure 1, below, is an illustration of this understanding, based on the ways in which my interviews highlighted the shared communal traumas experienced by clients and direct-service workers alike:

Figure 1: Nonprofit worker-client trauma in community context



Source: Author's creation, drawn from interviews.

Le Tim Ly, deputy director for the Chinese Progressive Association (CPA) in San Francisco, spoke of the “stresses and pressures” facing the mainly Chinese immigrant population served by his agency: “Thinking about the increase of anti-Asian violence, the tension between Black and Asian communities, in the context of White supremacist culture, there is so much [healing] that needs to happen at the personal, interpersonal, and institutional level[s]” . He listed some of the sources of trauma for Chinese populations of San Francisco prior to the COVID-19 pandemic:

For working class, poor, and underemployed folks, it’s just economic stability and survival. Cramped housing environments ... you might have three generations living in a room together. The pressures of that are significant. The pressure to do well in school, for young people, is high. Job and housing insecurity. And of course the issues of D.V. [domestic violence] are also prevalent. Addiction, gambling.

Because CPA makes a deliberate effort to hire from the community it serves—“A number of the staff come from our youth programs”—there is no clear line between the trauma of the community and the trauma of staff .

Hiring, retaining, and promoting

My interviewees agreed that hiring “from the community” they served was not enough to be able to say their organizations were successfully achieving diversity, equity, and inclusion. special attention to the wellness of these staffers was critical for retaining them and ensuring they could advance in the organization. Amy Walker, the White director of a legal services office in the

northeastern United States (the only one of the interviewees to request pseudonymity), said her adoption of TIA was part of a deliberate effort to recruit and retain staff of color:

At least at our organization, it requires a ton of training for people to work. Retaining people at the organization is huge, and nonprofits often burn people out. And especially for nonprofits that really value DEI, you don't want your staff of color to burn out more quickly because they're experiencing trauma and they're not feeling supported, and so it was more sustainable for staff to not burn out and leave the organization.

Tirien Steinbach is the former executive director of the East Bay Community Law Center (EBCLC), a legal services organization in Berkeley, California. (I worked at EBCLC from 2009 to 2012, when Steinbach was director.) Steinbach, who is Black, put the matter even more bluntly: "If you talk about DEI, there's no question that trauma is part of that ... If you do believe in broader societal trauma, then the idea that we would hire people from that community who wouldn't be impacted by it is ridiculous."

In one case, race, racism, and DEI were the principal frameworks the interviewee was using to think about TIA as it related to staff. Zoë Polk, the current executive director of EBCLC (which Steinbach led previously), mostly framed TIA in terms of improving services for clients. (I worked alongside Polk for about three months in 2010 when I was employed at EBCLC.) When asked directly about secondary trauma for her staff, Polk, who is Black, responded by citing news events in the past year that had been especially traumatic for her Black and immigrant employees:

Police killings and trials that result in non-guilty verdicts, more recently hate crimes towards Asians, immigrant detentions, 1/6 [the storming of the capitol on January 6,

2021], are all triggering. I've named it directly to staff, sometimes directly to Black-identified staff. That's one piece, naming it: "I know this is a struggle for you, and here's what resources I have [to offer you]."

Walker, of the northeastern law office, also spoke of needing to take a race-conscious approach to understanding how her staff might be impacted by traumatic news. Mentioning the May, 2020 murder of Black Minneapolis resident George Floyd by a White police officer, she described a lot of layers for staff of color, in particular Black staff, with whom I talked about trauma watching what was happening and feeling like they still needed to show up at work and do their jobs, but then [were dealing with] the trauma of the clients they were also working with."

Walker noted that the lack of diversity in her own organization and partner organizations could make processing the trauma of racist violence in the news even more difficult for Black staffers:

A lot of the times the spaces they were working in were more White, or more clinical, and [their colleagues] weren't necessarily experiencing the same emotional—not everyone, especially not White people, might have been feeling the same emotional response. Some staff were able to compartmentalize it and be highly productive staff members, and some staff just needed to tune it out or take care of themselves in [different] ways.

Polk, of EBCLC, said she was putting a priority on hiring staffers who have already spent time thinking deeply about racism: "I want people to come in with awareness of racial justice. It's a requirement for new people coming in." Yet it's been especially hard to recruit Black and Latin

attorneys, who are currently underrepresented on her staff in comparison with the population the organization serves: “Who can afford to work for this salary is part of” the difficulty, she said.

Jen Ventura, director of model implementation and assessment at the Seneca Family of Agencies, voiced similar concerns. Seneca is a nonprofit that delivers mental health services for youth and families in multiple locations in California. As at EBCLC, the racial/ethnic makeup of Seneca’s staff does not match the population the organization serves, though Ventura sees that “shifting for the better”, including making the hiring of staff fluent in Spanish “an explicit goal” to reflect a demographic shift from Black to Latin American immigrant in cities like Oakland and Richmond. Beyond just hiring representative staff, Ventura echoed Walker’s thoughts on the difficulty of retaining staff of color. For employees who start in entry-level positions, she said, their advancement “really depends on staff experiences to get formal and informal training, to grow.” The organization has had to ask itself, “Is there a difference if staff is supervised by staff of color or not? How does that impact their growth and retention?”

Supporting staff in times of crisis

Walker gave a vivid example of how communal trauma and an individual employee’s trauma can overlap, and how hard it can be for an organization to support an employee in an acute crisis. At Walker’s law office, an employee from an immigrant family had the stressful job of staffing the client hotline, which meant not only hearing people’s “traumatic stories,” as Walker put it, of detention and deportation, but also having to turn many of those people away because their the organization could not help with their particular cases. At the same time as she handled this workload, the employee’s family was experiencing its own issues with the

immigration system. It became clear that her mental health was suffering, and that her work was suffering as a result: “We were tiptoeing around it for a very long time,” Walker said. “We were very supportive, but at some point she was unable to work ... Having people not called back because you’re depressed is a hard thing to navigate.” In the end, the Walker put the employee on leave and she “ended up disappearing from the association, and we found out she had checked herself into a mental health facility.” Aside from speaking to the overlapping pressures felt by staff members “from the community,” this anecdote illustrates how hard it can be, even at a thoughtfully run organization, to find the appropriate balance between TIA for clients and TIA for staff.

Special attention to the experience of Black staff members and other staff of color was also a TIA priority for Ventura, of Seneca. Ventura, who is White, leads a team that does not engage in direct services but rather provides support for Seneca employees who work as counselors in public schools. Her team conducts trainings, including on TIA, for those counselors as well as school staff. Ventura said that TIA has been at the heart of Seneca’s work for decades, including an awareness of secondary trauma in staff, but the national “reckoning with racial justice” of 2020 has brought the issue to the fore, in part because Seneca serves a largely Black and Latin population:

I think for the staff who are in the community, in the schools, including virtually, the work has always been stressful. All the incidents of violence and racial injustice—the staff feels a very strong responsibility to make space for students. That work has been really important and really draining. Every week we talk about how to hold space for

students for the next horrific thing that happens. For staff, it's really meaningful, it's why they do this work, but also really exhausting.

Inspired by the work of Ginwright (2018) on "healing centered care," Seneca has implemented regular healing circles, facilitated spaces where staff are encouraged to talk through difficult feelings as a group, as well as practicing mindfulness techniques such as breathing exercises and body scans. Recognizing the distinct experiences of staff of color, the organization has experimented with separate healing circles for staff of different racial backgrounds, called affinity groups. Feedback has been mixed, Ventura said, as employees of color see some value in these separate circles, but their more pressing concern is to hear directly from their White colleagues: "We process this all day, every day," Ventura summarized their feedback. "We don't need a special place to process it. They're interested in understanding their white colleagues and hearing what we're going to do about these things. If they're in a different space, they don't get to hear how we're thinking".

Professional versus personal identities in the trauma-informed workplace

The second major theme of the interviews was the tension between professional and personal identities caused by the introduction of trauma-informed discussions in the workplace. Much of the literature on TIA implementation, as far as it touches on staff, focuses on staff adoption of or resistance to the new framework of TIA (cf. Bloom and Farragher, 2013; Hales et al, 2017; Hales et al, 2019; and Kusmaul et al, 2015). In general, the interviewees perceived little pushback from their staffs on the value of TIA for clients. Walker, of the northeastern law office, reported that

her staff attorneys from the region were less likely to embrace yoga and breathing exercises than those from the West Coast, but did not consider this a significant obstacle to change.

TIA trainings: mandatory or optional?

Leaders interested in implementing staff-facing TIA thus face the question of to what extent they require staff to engage with it. Ventura said that Seneca has made healing circles and other discussions on trauma “opt-in” for staff, but mandatory for the organization’s leadership team. Walker introduced TIA in small doses, having her most enthusiastic staffers lead mindfulness exercises or short yoga lessons at the start of regular meetings. “Integrating it into things, like five minutes at the start of a staff training, seemed easier than getting people to do a multiple-day training. Walker *did* offer staff the chance at multiple-day trainings; she just did not require them to attend. Steinbach followed a similar approach, adding a component of mindfulness to every staff meeting and having an enthusiastic assistant program longer talks and trainings on an occasional basis. She saw the small doses of TIA in the staff meetings as successful advertisements for the opt-in events: “You’ve got to link the mandatory stuff to the optional stuff. You have to have a mixture. It’s like A.A. [Alcoholics Anonymous]: if you don’t want to be here, it can’t really work.”

Ly, of CPA, said that most of his staff had embraced the self-reflective side of TIA but stressed that the organization was not interested in forcing talk of trauma on hesitant employees. Several years before the COVID-19 pandemic, an employee at CPA persuaded the leadership team to begin offering trainings in somatics, a mind-body discipline that takes various forms but often encourages participants to reflect on how their bodies store traumatic experiences as part of

a psycho-spiritual healing process (Generative Somatics, n.d.). Of the somatics trainings, Ly said, “Maybe ten percent of folks didn’t want to do it and deal with their baggage, or have it dealt with in a public setting.” The solution, for CPA, was to offer a sort of spectrum of engagement:

At some retreats, some people might just opt to stay out of certain activities. For the folks who don’t want to do it, they still see value in why it’s helpful. You may not want to bring that part of yourself into your workspace. You still have to kind of figure out the right balance ... There are many factors. Each individual person needs to think about it for themselves.

What mattered most of all to the success of these sensitive trainings, Ly said, was having a good facilitator who could create a “container of safety”—that is, who could inspire trust and adjust the pace of the discussion in response to the level of receptivity among the participants:

You need well trained people to handle the things that might come up. People shouldn’t just haphazardly do it ... It’s important to ease into it, to be able to read your team as you’re moving through it. With so many things, it’s needing to do testing and assessment consistently to get the feedback you need to adapt. I don’t think there’s a right way to do it. Creating the opening ideally improves things.

Pinderhughes agreed that introducing trauma-informed concepts is inadequate if the teaching is done poorly: “The process is critically important. The training is critically important.”

Bloom and Farragher take a tougher tone in *Restoring Sanctuary* (2013) than did any of the interviewees. As TIA experts who have helped many organizations undergo a trauma-informed transformation, including Farragher’s own, the authors acknowledge that not all

employees will get on board when these new ideas are introduced. They estimate that about 20% of employees will be “never-adopters” who, if they “discover this is a place where they are no longer happy,” need to leave on their own or else “be shown the door” (Bloom & Farragher, 2013, p. 280). If this sounds harsh, it should be read in the context of Bloom and Farragher’s advocacy for much greater organizational democracy and staff empowerment as key elements of TIA.

Unlocking the trauma “box” at work: a question of clashing identities

Where staff seemed to hold the most complicated feelings about TIA, at least as far as my interviews reported, was in the approach’s implications for discussing difficult feelings or personal histories in the workplace. Steinbach, formerly of the law office EBCLC, warned that asking nonprofit workers to show up as their authentic selves is asking them to blur the lines between their personal and professional identities in a way that may be deeply unsettling for them. “I can’t maintain my professional identity and deal with my trauma,” she imagined a hypothetical employee protesting, “I’ve got it locked in a box over here.” Ventura, of the youth-serving Seneca Family of Agencies, suggested that maintaining a hard psychic division between the home and the workplace might be a form of self-protection for her staff of color “who came from communities we serve. They have to compartmentalize. They have to set aside what they do at home to show up for students and staff. They don’t get a break.” Therefore, asking staff of color to discuss trauma at work may be adding a burden to the very employees already likely to be carrying the heaviest emotional loads.

Steinbach, an enthusiastic advocate for TIA who has brought its tenets both to EBCLC and later to the ACLU of Northern California, nevertheless expressed sympathy for employees who do not want to open the “box” of their trauma at work. She described the nonprofit sector as still “wrestling between these two paradigms” of distanced professional and personal vulnerability:

The separations people make and maintain, I understand them. They might go into work like therapy in part because of their own trauma, and as part of their own identity formation they try to separate from that trauma and try to manifest their trauma in a productive way.

Steinbach, whose father is a physician, noted that in fields like medicine, “with hierarchy and set roles,” the idea of bringing one’s “authentic self” into the workplace can be antithetical to the whole professional culture: “You wear a uniform. When you’re in this space, you’re in a role. And now there’s this shift, in nonprofits and corporations, to: ‘What would it look like to show up as yourself?’” For all her support for nonprofit workers learning to recognize trauma in their clients and in themselves, she is not ready to endorse the total merging of professional and personal identities. As she put it, “We as managers should not say we want people to bring their authentic selves. No.” Rather, she said, it is the role of managers to shape a workplace “with shared values and expectations, to carry out the organization’s mission.” To suggest we all be our full selves at every moment “creates a very weird expectation” that is incompatible with the responsibilities of working in an organization, Steinbach said, “because my authentic self is sometimes underneath the blankets all day, reading a book.”

The cognitive dissonance Steinbach described, of employees confronting the introduction

of personal trauma into the professional environment, also ties into the question of just how empowering TIA can be for staff. Bloom and Farragher note, with some humor, that many employees respond with suspicion and even outright resistance when leaders implementing the Sanctuary model of TIA start talking about “subversive ideas” like workplace democracy and shared decision-making: “the first reaction is that the person is either kidding or has totally lost his mind ... when leaders change, the first response of the followers is skepticism, followed quickly by a frenzied effort to get leaders to behave the way they always have” (Bloom & Farragher, 2013, pp. 285–286). For Steinbach, staff resistance to organizational democratization is another sign of people struggling to adjust their sense of self in the workplace:

At EBCLC, when I tried to broaden who was part of decision-making, there was resistance all around, including from people who were like, “Wait, I don’t want to be the man. I want to reserve the right to stand outside [of leadership] and criticize management.” It was anathema to their professional identity.

Some solutions: passion projects, advocacy, and the importance of patience

This is the third and final subsection of my analysis. All of the interviewees had found ways to implement TIA that they saw as benefitting staff. In Section 5, below, I will summarize these.

Some of the solutions the interviewees identified are by now familiar, albeit far from universally implemented, within the nonprofit sector. Walker and Steinbach both mentioned sabbaticals as useful tools for employees to recharge. Ly touted CPA’s liberal policy on allowing employees to shift between full- and part-time schedules “pretty readily” as an important way of retaining workers in a stressful field. Perhaps most prosaic of all is the issue of pay. Polk named

“paying people wages to live in the Bay Area” as an important part of being a trauma-informed employer.

Side projects: passion and advocacy

Nearly all of the interviewees mentioned some form of what Ly called “passion projects, something that’s feeding them, to sort of balance out other things that might be challenging.” Sometimes these were directly related to TIA, as with Walker’s employees who led breathing and yoga exercises for the staff, or Steinbach’s assistant who took charge of programming trauma-informed talks and workshops. But other sorts of projects worked as well. “People who had lots of client work, we tried to make sure they had other projects”, said Walker. For one of her hotline workers, this meant getting to design and lead know-your-rights trainings for immigrants: “She got to be with people who weren’t necessarily experiencing trauma, and she got to empower them. She [also] got involved in a winning advocacy campaign.”

Advocacy side projects came up with several of the other interviewees as well. Steinbach recalled the positive effect of a national convening that EBCLC’s Clean Slate program, which helps people expunge criminal convictions from their records, got to participate in: “It helped us see ourselves, define ourselves, as part of a movement of transformation.” Ventura also spoke to the power of getting employees involved in policy work; examples in recent years involved a lawsuit against the Trump administration about family separation at the border, advocating for “alternatives to police intervention” in Bay Area counties and municipalities, and convincing San Francisco to expand eligibility for mobile mental health crisis services to all families . Agency-

wide staff satisfaction surveys at Seneca have provided evidence of these projects' impact on staff morale:

I've noticed that those things that address things our staff are really passionate about, it really impacts their connection to the agency and their sense of hope, in the long-run ... I was surprised how often folks are naming that as something that makes them really proud to work for the agency.

Why is advocacy work apparently effective as a means of combating burnout among direct-service workers? I believe the explanation has something to do with the sense of connection fostered in people who see themselves as doing something to improve conditions for a community as a whole. As the federal mental health agency SAMHSA put it in its 2014 report on TIA, "healing happens in relationships and in the meaningful sharing of power and decision-making" (p. 11). Put even more simply: just as trauma is experienced communally, so too is healing (cf. Pinderhughes et al, 2014, and Schultz et al, 2016).

Nevertheless, Ventura noted a serious deficiency in passion projects as a solution for all staff. Employees in direct-service and administrative roles such as billing, she said, were much less likely to feel able to take time away from their daily responsibilities. In response, Ventura and the rest of the leadership team had come up with

a series of conversations each month that all supervisors were expected to go through with their staff about workload balance. What are those growth/passion opportunities? Making really explicit structure for each supervisor to have that conversation: "What's getting in the way?" I by no means think it's perfect, but it's been a big step to make it a program-wide expectation.

Taking a broad view of advocacy, we might include participating in protest movements as another way nonprofit workers find a meaningful connection to their field outside of their daily responsibilities. Walker, the only interviewee to mention this specifically, said she took a stance of “just telling people that if they needed to be out, they could be out” to attend demonstrations, “especially around the Black Lives Matter protests” (A. Walker, personal communication, April 8, 2021).

Workloads and the culture of urgency

For some leaders, making TIA serve staff was a matter of reducing workloads as much as possible. All the interviewees shared a general sense that the normal condition of nonprofit workers is to be crushed beneath overwhelming workloads. Polk, who of all the leaders interviewed was least-focused on the staff side of TIA, saw workload reduction as the single best thing she could do for the mental health of her staff while also benefitting clients:

When I think of *trauma-informed*, I want to convert a significant number of EBCLC’s dollars into general operating. Government assistance is very deliverable-heavy. The staff experience, if they’re not tied to deliverables, is that they can focus on solutions that change people’s lives. Money is a big part of it.

Deliverables, in nonprofit speak, are commitments that grantees make in exchange for government funding, usually tied a specific number of discreet services rendered to clients. Intended to make nonprofits accountable for the public money they receive, deliverables also have the effect of concentrating organizations’ focus on the quantity of services over their quality.

Walker also cited financial flexibility as a key to staff-side TIA. As a law office charging legal fees for cases rather than fulfilling government grants, “We could expand or contract our work as we wanted.” She also tried to model a healthy work-life balance and set “expectations of people not working all the time.” Still, she noted, “It was very hard for people to say ‘no’ to things ... There was a culture of doing everything you could on a case” to prevent a client’s deportation.

The widespread culture of overwork in human service nonprofits surely is related to the high stakes of clients’ well-being on the line. Steinbach, though, suggested the deeper problem is a “sense of urgency” that is rooted not specifically in high workloads that could be adjusted, but in “White-supremist culture.”² This realization crystallized for her, she said, when she left EBCLC after 17 years there to work for the ACLU. Despite going from a direct-services organization, where there was a daily focus on preventing immediate consequences for clients such as eviction, to an organization doing long-term advocacy work, she encountered “the same sense of urgency and impatience.”

One consequence of feeling constantly in crisis, Steinbach told me, was that “It’s really hard to step back and redesign programs. Trainings feel like an impossible use of time.” She found that her perspective on certain employees at EBCLC had changed over the years. “In a way I first misread” staff members who appeared more relaxed, she said. ““Do they not care about this work?” But over time, I realized, no, they’re just not showing up and perpetuating trauma with this constant sense of urgency.” Instead, those employees were the calmest affects

² Okun (n.d.) identifies “sense of urgency” as one of fifteen defining characters of what she calls *white supremacy culture*. The terms *white supremacist* and *white supremacist* are interchangeable.

were often the ones who managed to work for years and years in a stressful setting without burning out.

The antidote to White-supremist urgency, Steinbach said, was not more urgency but rather patience: patience with clients, patience with ourselves, and patience with our organizations. Bloom and Farragher also emphasize the importance of leaders modeling patience in the transition to TIA. Writing about the staff resistance to democratization mentioned in my previous section, they recall that Farragher himself, to show the staff these changes were not going away,

had to sit and wait patiently for everyone else's participation. But leaders usually become leaders because they are action-oriented. Brian had to learn to bite his tongue but his face usually shows what he feels, so that was not always an effective strategy. It is clear now that the patient waiting he did was essential to moving ... Waiting for [his employees] sent a not-so-subtle message that he wanted them to come along. (Bloom & Farragher, 2013, p. 285)

Steinbach cited back to me my own motto from my time at EBCLC, which I had written on a small sign next to my desk when I worked there: "Patience is expedient." Steinbach she said she had gone on, after I had left the organization, to display this "Owen Thompson-ism," as she called it, around the office at EBCLC and later at the ACLU . This slogan, as she understood it, was partly about a way of "approaching, engaging [clients] ... bothering to sit down and be compassionate and show up and bear witness." (I agree that this description matches how I intended the phrase to be interpreted.) But, she cautioned,

“Patience is expedient” isn’t just about the client in front of you ... It is also about changes in organizations ... Trauma isn’t worked through in any urgent way. There’s no way ... There’s an urgency now that people should know how to say and do the right thing. And it’s like, we’ve spent hundreds of years doing and saying the wrong thing, why don’t we give ourselves a little more compassion and patience about change, also?

Section 5: Recommendations for Human Services Leaders

- Integrate TIA into DEI policies. These should not be two separate conversations but a single one. Supporting a diverse staff, especially staff of color, means recognizing how trauma impacts specific communities.
- Maintain reasonable workloads and flexible schedules. This might mean more general operations funding to alleviate the burden of constantly struggling to meet deliverables. Burned out staff-members perpetuate a traumatizing work environment.
- Replace a culture of urgency with a culture of patience. Do not rush TIA or expect quick results. Its implementation should be an ongoing evolution, not a checking of boxes.
- Offer a mix of mandatory and opt-in TIA training. Some number of employees will never like the idea of discussing trauma in the workplace in any capacity, but others will grow increasingly open to TIA with small exposures in formats like staff meetings.

Section 6: Conclusion

This project found rich topics of interest, but much more remains to be studied on the question of TIA as a tool for staff wellness. My use of convenience sampling, while necessary in a time of crisis when it was hard to recruit nonprofit leaders, led to an over-representation of nonprofits that provide legal services and those located in the San Francisco area. A larger qualitative study would include leaders of a wider range of human services. It would be interesting, among other things, to see if nonprofit leaders operating in primarily White, or rural or suburban, communities would have different perspectives on the importance of race and DEI to their implementation of TIA. For instance, would the socioeconomic class of employees become more prominent in their thinking?

The leaders I spoke to were thoughtful about using TIA to support and retain their staff, but in most cases had not measured their efforts using quantitative or qualitative methods. (Seneca appeared to be the exception, using regular staff satisfaction surveys to guide its evolving implementation of TIA). As noted in the review of literature, several studies have attempted but largely failed to produce reliable quantitative data on the success of TIA implementation at improving staff well-being. Studies based on surveys have struggled to obtain a representative sample of the nonprofit sector that cuts across sub-sectors (healthcare, education, human services, etc.) and organizational hierarchies. They have also been unable so far to connect pre-post responses to individual respondents. It is also clearly difficult to conduct studies that track retention rates across different organizations with differing levels of TIA implementation; there would have to be many organizations and a high level of scrutiny to screen

confounding factors, and in any case it would take years of retention data to be meaningful. The ideal study would have complete surveys from all staff, as well as access to human resources data and the ability to observe operations in-person over time. Such a study would only be possible with a strong commitment from the highest levels of leadership in multiple nonprofits. It would be difficult to accomplish. If achieved, though, it could be a powerful tool for bringing skeptical leaders to embrace TIA as an approach that benefits both clients and staff.

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Appendix A: List of Interviews

Expert interviews

Canizales, Stephanie. Assistant professor of sociology, University of California – Merced.

Interviewed by Zoom, April 12, 2021. Prof. Canizales is currently studying the impact of trauma on detained immigrant minors and their caregivers, including nonprofit workers.

Her research focuses on Southern California and Harris County, Texas.

Pinderhughes, Howard. Professor of social behavior sciences, University of California – San

Francisco. Interviewed by phone, March 9, 2021. Prof. Pinderhughes' research includes writing on youth, violence, and the communal and structural nature of trauma. He has conducted research in New York City, the San Francisco Bay Area, and Malawi, among other places.

Nonprofit leader interviews

Ly, Le Tim. Deputy director, Chinese Progressive Association (CPA), San Francisco.

Interviewed by phone, April 21, 2021. Ly has worked at CPA for 14 years, in the deputy director role for all of that time. His background is in community organizing.

Polk, Zoë. Executive director, East Bay Community Law Center, Berkeley. Interviewed by phone, March 30, 2021. Polk is an attorney. She was hired as executive director of

EBCLC in January 2020; before that, she served as Deputy Director of the San Francisco Human Rights Commission.

Steinbach, Tirien. Former executive director, East Bay Community Law Center, Berkeley.

Interviewed by phone, April 13, 2021. Steinbach is an attorney. She began at EBCLC as a fellow and spent 17 years at the organization, including eleven years as executive director. She left EBCLC in early 2019 to become Chief Program Officer for ACLU of Northern California. She left ACLU in February, 2021, and is currently on what she calls a “self-care sabbatical.”

Ventura, Jennifer. Director of model implementation and assessment, Seneca Family of Agencies, California (multiple locations). Interviewed by phone, April 25, 2021. Ventura has worked at Seneca for nearly 19 years. She has held her current position for almost nine years. Seneca provides mental health services, but Ventura does not have a clinical background.

Walker, Amy (pseudonym). Former executive director of a nonprofit law office serving immigrants in the northeastern United States. Interviewed by phone, April 8, 2021. Walker is an attorney. She spent just over ten years at her law office. She held a managerial position of some kind the entire time and was executive director for her last five years there. She stepped down in late 2020 and currently operates a private legal consulting practice.

Author's Bio

Owen Thompson-Lastad began his nonprofit career in 2006 as a paralegal and outreach worker for Farmworker Legal Services of New York (now named the Workers Justice Center of New York) in Rochester, New York, where he focused on wage theft, pesticide poisoning, and human trafficking. After relocating to the San Francisco Bay Area in 2009, he served as program manager for the Neighborhood Justice Clinic, a project of Berkeley's East Bay Community Law Center specializing in consumer rights and the civil rights of the unhoused population. From 2014 to 2018, he coordinated the Bay Area's largest free tax-preparation site at the Mission Economic Development Center, in San Francisco's Mission District. He has been a full-time parent and sometime graduate student since the beginning of 2019.