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A Curriculum on Culturally Competent Practices to Prevent Retraumatization in Diverse Survivors

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Abstract

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by

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MSN, Columbia University, 1993

BSN, New York University, 1984

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

This DNP project addresses the healthcare issue of intimate partner, domestic, and sexual violence (IPDSV), its impact on survivors, and reducing the potential for retraumatization by those who care for them in the clinical, behavioral, and social settings. Trauma-informed care interventions are designed to address the sequelae of trauma, promote recovery, and support resilience. Since IPDSV is a global health issue, supporting cultural needs of all clients is an essential aspect of trauma-informed care. This project was guided by a central research question that examined if a trauma-informed, culturally competent curriculum be viewed by community stakeholders as an appropriate intervention for the education of their workforce in preventing survivor retraumatization. The following three frameworks informed this project: The framework for this project was informed by the sanctuary model, the 4 major tenets of Leininger's theory of cculture care diversity and universality, and the 5 constructs of cultural competence by Campinha-Bacote. The focal site was a domestic violence organization that provides care for a multitude of culturally diverse trauma survivors. Demographic data were collected, and a descriptive analysis performed to determine the diversity and needs of the residents. These data were then used to develop a culturally competent program using trauma-informed principles to prevent the effects of recidivism, and to promote healing, empowerment, and resilience in survivors.

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Dedication

My work is dedicated to all diverse survivors of domestic and sexual violence. I offer my deepest apologies for all of the heinous experiences you had to endure in your lifetime and for all of the contacts that triggered those experiences again when you sought help. Please forgive us.

To all those survivors who at their right moment, decided to disclose yet never returned for help. I truly hope that you return soon.

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Section 1: Overview of the Project

Introduction

Each year, millions of men, women, and children across the globe endure abuse, neglect, and maltreatment, the majority of which is at the hands of those closest to them (Smith et al., 2013). The victims that receive behavioral, social and medical health services, trust that their providers will heal their physical injuries, wounded psyche, and emotional states. According to Felitti and Anda (2010), the unaddressed psychological and physical impact of these adverse experiences, especially those early in life, are correlated with, (a) many social, emotional, and cognitive impairments, (b) chronic health conditions, (c) using high-risk behaviors as coping mechanisms, and (d) an increased risk of early death.

Historically, the impact of trauma was either negated or prioritized as a source of suffering (Ringel, 2012). The inflexible rules, lack of confidentiality, and the punitive practices of traditional healthcare systems induce retraumatization (Jennings, 2008). For example, blaming the victim for the trauma is a consequence of provider denial, and justifies a way to disallow empathetic reactions and the obligation to intervene (Zur, 2016. Clinicians may be skeptical and resistant to engaging in trauma-informed practices, which often stems from a lack of knowledge about the effects of trauma, a concern about one's ability to respond appropriately and in some cases, the providers' unresolved personal traumas such as dealing with fear, shame, hypervigilance and traumatic triggers (DeCandia & Guarino, 2015). Trauma is central when pursuing a

solution to deal with human distress for those clinicians who are receptive and understand its impact (Baillot, Cowan, & Munro, 2013).

The non-profit host organization is one of the largest domestic violence shelters in the United States (Strategic Plan 2015-2020). Since 1977, it has provided shelter and support services to thousands of women and children of diverse cultural groups affected by violence (Strategic Plan 2015-2020). The organization offers emergency shelter, transitional housing, health services, case management, lay legal services, pet services, and community outreach. The organization's vision statement, A World Free from Domestic Violence is an example of their goal to reach a high level of service or the women and children they serve. It has a new mission of expanding its safety net of services for women, children, men, and pets. One objective is to address the diversity in their resident population. With the development of its renewed Strategic Plan, the organization realized that it needed to improve cultural competence in its daily practice. It is of utmost importance to be culturally sensitive to diverse populations; it helps prevent revictimization and supports recovery (Strategic Plan, 2015-2020). The purpose of this project was to develop a curriculum on trauma-informed, culturally sensitive care that promotes awareness to prevent retraumatization among survivors at the organization.

The socioecological framework (CDC, 2015) supports the examination of all possible influences on the victim's ability to heal, to become resilient, and to be empowered. Service providers need to acknowledge the individual, interpersonal, the communal and societal milieu in which the survivors exist, which provides insight into their culture and norms. However, it will require a unified commitment on the part of the

Stakeholders, namely the C-suite personnel, board members, and the frontline employees such as the intake staff, clerical and food services, and the direct care providers of the DV organization. At the minimum, cultural competence as a facet of trauma-informed practice is not harmful and may help to prevent repeated adverse experiences within the system. It is difficult to ignore the expression of pain and fear, as seen in the eyes of those affected by violence. As stated by Sonmi-451 in the film, Cloud Atlas (Tykwer, 2012), "Our lives are not our own. From womb to tomb, we are bound to others, past and present, and by each crime and every kindness, we birth our future."

Problem Statement

The prevalence of intimate partner, domestic and sexual violence (IPDSV) in the United States is a serious public health concern (CDC, 2011). IPDSV is a critical problem for victims that can lead to serious short- and long-term consequences, including physical injury, poor mental health, and chronic physical health problems (WHO, 2012). The most recent National Intimate Partner and Sexual Violence Survey commissioned by the U. S. Centers for Disease Control and Prevention reported that one in three women in the United States have been physically assaulted, or stalked by an intimate partner (Black et al., 2011; Walters, Chen, & Breiding, 2013). As of 2010, 3.2 million women in the United States have experienced severe physical violence by a partner in their lifetime. This equates to one in four women or 20 women per minute (Black, et al., 2011).

Another component of SV against women is sexual assault, one of the most widespread of human rights violations (WHO, 2012). Sexual assault arises through intimate relationships, familial kinship, and strangers. According to the National

Incident-Based Reporting System (NIBRS, 2012), 346,830 total women were sexually violated in the United States. Sexual violence includes sexual coercion, unwanted sexual contact, non-contact unwanted sexual experiences, or rape involving penetration (CDC, 2011). Sexual violence may occur without a victim's consent, or when a victim is unable to consent, for example, due to age, illness, or mental incapacity (CDC, 2009 (Basile, Espelage, Rivers, McMahon, & Simon, 2009). One in five women have experienced an attempted or completed rape in their lifetime defined as penetrating a victim through use of force or through drug-facilitated action (NSVRC, 2015). Nearly one-third of women experienced some form of non contact wanted sexual experience in their lifetime (Basile, Smith, Breiding, Black, & Mahendra, 2014). The research shows that 95% of women are victims of IPDSV (Mallicoat & Estrada Ireland, 2014). Therefore, this project will focus on supporting women and their children.

Children Affected by Violence

The impact of domestic violence on children is shown in the most recent percentages as follows:

- Over 5 million children (~7%) in the United States have been exposed to physical violence (Hamby et al., 2011).
- Nearly 1 million children (~1.3%) in the United States have been exposed to serious violence, for example, kicking, choking, and beating (Hamby et al., 2011).
- About 4.3 million children (~5.7%) have been affected by psychological or emotional violence (Hamby et al., 2011).

- About 8.3 million children (~11.1%) have been exposed to physical or psychological violence between adults or between adult and teen (Hamby et al., 2011).

Children being exposed to intimate partner violence (IPV) is associated with a host of mental health conditions both in youth and in later life (Felitti & Anda, 2010; Hamby, Finklehor, Turner, & Ormrod, 2011). The experience most likely to placed children at risk for trauma is eye witnessing violence, which accounted for 65-86% of all exposure (Hamby et al., 2011; Futureswithoutviolence.org, 2016).

The retraumatization of survivors is a widespread issue in the healthcare system. Repeated trauma when in the care of providers, potentially activating adverse memories, has been associated with symptoms that extend beyond traditional posttraumatic stress disorder (Duckworth & Follette, 2012). One area of healthcare that has demonstrated the greatest risk of retraumatization is Women's health. The traditional lithotomy position and breast evaluation, which triggers recollections of adverse experiences, causing embarrassment about undressing and fear of pain, are emotionally the most difficult aspects of the examination (Simkin & Klaus, 2013). The Healthcare Retraumatization Model (Dallam, 2010) describes a cyclical pattern comprising of four interdependent processes: (1) hypersensitivity to threats to safety, (2) exposure to triggers, (3) post-traumatic stress reactions, and (4) avoidant coping. Trigger reactions may encompass emotional responses such as anxiety, panic, flashbacks, crying, guilt, shame, anger, grief, fear, sadness, despair, or hopelessness; physical reactions such as dizziness, headaches,

shaking, nausea, or vomiting, and delayed responses as in nightmares and insomnia (Dallam, 2010).

Retraumatization can be a vicious cycle wherein repeated trauma exposure confirms the survivors' perspective of healthcare as a frightening experience. The encounter will in turn, enhance the survivors' sensitivity to menacing cues during subsequent healthcare visits. Avoidance rather than addressing the issues forthright creates a perpetual cycle (Dallam, 2010). There is the potential for adverse outcomes when survivors' need to self-preserve resulting in their failure to participate in preventative healthcare, failing to seek timely treatment for serious illnesses, refusing treatments they find objectionable, failing to adhere to treatment regimens, leaving treatment against medical advice, or failing to return for follow up care (Dallam, 2010).

Arizona Statistics

Arizona is a diverse state, consisting of not only city, suburban, and rural areas but also 25% of tribal land. The largest city in the state is Phoenix, which also is the sixth largest city in the United States comprising of 1.4 million people in 2014 (Governor's Office for Women and Children, Youth, and Families, 2014). Maricopa County, within the Phoenix area, accounts for 60% of the total Arizona population. In the state of Arizona, one in four women experience domestic assault in their lifetime. One-third of the women are victims of violence-related homicides committed by intimate partners (Arizona Coalition Against Domestic Violence, 2014). For the year 2014, 2,445 cases of rape were reported which translates to one rape committed every three hours and eighteen minutes (Arizona Department of Health Services, 2010). Due to the problem of

underreporting in many cases, the statistics may not reflect the true incidence of sexual victimization (AZDHS, 2010). In a statement submitted by the Arizona Criminal Justice Commission (AZCJC, 2015), the rate of forcible rape between the years 2004-2013, increased in Arizona from 33.0 per 100,000 to 35.4 per 100,000. The overall rate of rape nationally during that time decreased from 32.2 to 25.2 per 100,000 (AZDHS, 2010).

Sexual perpetration by race and ethnicity. Although, the focus of this project was to address all diverse ethnic groups, an acknowledgment is in order about the widespread rates of sexual assault in the American Indian/Alaska Native (AI/AN) population. With a total AI/AN population of 379,590 (5.7% of the state's total population in 2014) and 21 federally recognized tribes, AI/AN women are at higher risk of violence compared to other ethnicities (AZDHS, 2015). In 2013, tribal jurisdiction reported 441 forcible rapes, compared to 419 in 2012 (AZDHS, 2015).

Emergency room visits and hospital discharges. In 2014, 218 emergency room visits and discharges documented in Arizona hospitals for the management of sexual assault injuries. The average cost for the emergency room visit was $2,668. With severe sexual trauma injuries that required hospitalization, the average cost of inpatient care was $36,360 (AZDHS, 2014). The rate of hospital discharges for severe sexual assault injuries increased 65% from 1.98 discharges per 100,000 in 2005 to 3.26 discharges per 100,000 victims in 2014 (AZDHS, 2014).

Barriers to care. Numerous barriers exist that delay a survivor of violence from seeking care. Some of these obstacles include fear of disclosure, concern about breaches of confidentiality, fear of retaliation by perpetrators, fear of law enforcement, their

reports of victimization not believed, economic and geographic barriers, and the lack of funding (Gebhardt & Woody, 2012). Real and perceived hurdles that first responders face when confronted with a survivor of violence include time constraints, lack of knowledge, education or training on the issue, inadequate follow-up resources and support staff, discomfort in discussing subject, apprehension regarding personal safety, and concern of misdiagnosis. Many providers fear invading their patient's privacy or offending them in some manner (Sprague et al., 2012).

Since violence appears not only to be societally accepted but also approved, primary prevention of domestic or sexual violence would be insufficient. Thus, the objective of this project would require secondary prevention to identify women in the early stages of abuse and implement strategies to eliminate retraumatization in their care (Kettner et al., 2008).

Financial costs. The estimation of costs for domestic violence alone in the United States, encompassing health, justice and the impact on social systems serving children at risk is $37 billion per annum. The lifetime cost for the care of maltreatment per child victim in 2010, was $210,000 (DeCandia & Guarino, 2015). The expenditures of such magnitude warrant an intervention such as the cost-benefit analysis (CBA) typically conducted when costs of an alternative strategy produce a single, common consequence (such as the reduction of trauma-related health issues). The outcomes are measures in natural units such as life years gained, cases of disorders averted or hospital admissions (Mazurek-Melnyk, & Morrison-Beedy, 2012).

Purpose Statement

The purpose of this DNP project was to develop an educational curriculum that provides a framework for the education and support of the DV staff; the curriculum is based on cultural competence, a component of trauma-informed practice. Trauma-informed principles offer a path of knowledge that supports an organization by enhancing, rather than discouraging, the identification of abuse (SAMHSA, 2014). The goal of this project is to teach the workforce at the organization about the dynamics of cultural competence, to provide support in acknowledging and understanding diverse cultural groups, and to plan culturally sensitive and trauma-informed approaches to care. The anticipated outcome is that the organization will become part of a larger collaborative response within the community through future community partnerships that support all victims, regardless of culture to prevent retraumatization. An assessment of the residents' demographic data will provide direction to meeting the needs of each cultural group and will guide program development while ensuring program accountability (CDC, 2014; White & Dudley-Brown, 2011).

Acquiring cultural competence with trauma-informed knowledge at its core is a holistic approach to effective health service delivery (SAMHSA, 2014). Trauma-informed practice requires a multi-factorial and multi-agency public health approach that includes public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment (SAMHSA, 2014). A trauma-informed organization provides access to culturally appropriate services, supports traditional relationships, acknowledges historical trauma, and implements processes using

policies and protocols that address the cultural needs of the community (SAMHSA, 2014).

Relevance to Practice

The cultural competence movement evolved due to a growing recognition of the significant disparities in health and social outcomes across ethnic and racial groups. Training in cultural competence promotes knowledge of how one's own beliefs and values influence victims' perceptions, feelings, experiences, and ability to cope with trauma (SAMHSA, 2014). The following organizations support

The National Center for Cultural Competence

The NCCC at Georgetown University (NCCC, 2015) defines cultural competence as, (a) having a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally, (b) having the capacity to,

1. Value diversity,
2. Conduct self-assessment,
3. Manage the dynamics of difference,
4. Acquire and institutionalize cultural knowledge,
5. Adapt to diversity and the cultural contexts of the communities they serve,

(c) incorporating the above in all aspects of policy-making, administration, practice, service delivery and involve systematically consumers, key stakeholders, and communities.

The Health Research and Educational Trust

The HRET division of the DHHS defines cultural competence as developing the skill and aptitude to offer appropriate care to patients that have diverse values, beliefs, and behaviors while adapting health care services to meet their social, cultural, and linguistic needs (HRETdisparities, 2013).

The National Culturally and Linguistically Appropriate Services

The CLAS standards in health and health care, developed by the Office of Minority Health (HHS), is an organization that takes it a step further and provides a blueprint with guidance and strategies for cultural competence implementation. The tenets of the CLAS include direction for governance, leadership and workforce, communication and language assistance, and engagement, continuous improvement and accountability (National Partnership for Action to End Health Disparities, 2011; ThinkCulturalHealth, 2010).

A culturally competent process within healthcare organizations has shown to improve health outcomes, promote mutual understanding among stakeholders, survivors, and the community. Such processes are considered cost-efficient (HRETdisparities, 2013).

Project Question

Will a trauma-informed, culturally competent curriculum be viewed by community stakeholders as an appropriate intervention for the education of the Domestic Violence workforce in preventing survivor retraumatization?

Evidence-based Significance of the Project

With the inception of the Adverse Childhood Experiences (ACE) study, Felitti and Anda (1998) discovered an association between early childhood maltreatment and adult health issues. The findings prompted the largest research study by Dr. Felitti to assess these associations. It involved more than 17,000 health maintenance organization (HMO) members disclosing detailed information about their childhood experience of abuse, neglect, and family dysfunction (CDC, 2016; Sadler-Riggleman & Skinner, 2015). The findings yielded the principles of trauma-informed care, and a global movement was implemented to facilitate healing by addressing the consequences of lifetime trauma. The results of the study suggested that these experiences are major risk factors for the leading causes of illness and death such as ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease, including the sequelae of these risks factors as being strong and cumulative. (Felitti & Anda, 1998). By implementing an approach that blends research, practice and survivor knowledge to manage trauma, and understanding the associations between adverse childhood experiences and later health conditions will improve efforts towards prevention and healing (SAMHSA, 2014).

The scientific evidence of epigenetics (Anway et al., 2005) shows the implications of intergenerational trauma. The research findings suggested that our genes carry memories of trauma experienced by our ancestors and influences how individuals react to trauma and stress in the present (Brockie et al., 2013; Sadler-Riggleman & Skinner, 2015). Epigenetic changes are an individual's molecular response to the environment and occur to preserve the health of the individual. The adverse childhood

experience most linked to the vulnerability for health-related issues is childhood sexual abuse (Edwards et al., 2012).

Implications for Social Change in Practice

Health care delivery cannot be all-inclusive without embracing the need for cultural competence. Domestic and sexual abuses constitute intimate acts, of shared physical and social realities, and frequently of shared or overlapping cultures and worldviews (Brown, 2008). Improving cultural competence is a key step to addressing the experience of trauma. Culture is central to identity and to the process of grieving, expressing pain, fear, and healing (Brown-Rice, 2013; PCAR, 2009). It provides a view about how to connect with victims and understand the events surrounding their trauma, while supporting recovery, resilience, and empowerment. Trauma interacts with a unique set of characteristics and experiences that each person carries within and brings to their encounter with dangerous, painful, and disruptive events (Brown, 2008; PCAR, 2009). Even the best practices lack efficacy when cultural competence is not incorporated as a trauma-informed solution (Brown, 2008). It is imperative that clinicians understand and examine the meaning of their own identities and biases in the observation of trauma, and the design and implementation of healing strategies (Ford et al., 2009). According to Brown (2008), cultural competency is a perpetual process requiring ongoing consultation and training, never fully reaching a plateau but always moving toward it (Brown, 2008). Social change will evolve only when service providers understand the evidence regarding adverse experiences early in life, recognize the survivors' worldview in the context of

trauma, and begin to strategize collaboratively to address the acute and chronic health sequelae of violence.

> Trauma is trauma is trauma. The texture of pain, the color of fear, and the melodies of cries are all human and shared. They are all, also, uniquely configured and ordered by human identities, cultures, heritages, and networks of relationships. (Brown, 2008, p. 258).

Definitions of Terms

Acculturation. It is understanding the degree to which individuals have adopted the traits of the new mainstream culture in which they reside (Lopez-Class, Castro, & Ramirez, 2011). Acculturation is a sociocultural process that occurs in multi-dimensional stages. The stages of adjustment are cultural assimilation and social assimilation in which, the individual will first try to understand the values, customs, and language of the new society followed by the social integration through their involvement in social gatherings, clubs or institutions (Lopez-Class et al., 2011). It is important to consider how diverse ethnic groups may assimilate differently based on their unique environmental experiences, cultural orientation or existing political turmoil occurring in their country and the impact it has on acculturation and health outcomes (cited by Lopez-Class et al., 2011).

Cultural awareness. It is the self-examination and in-depth exploration of one's cultural and professional background (Campinha-Bacote, 1998, 2002).

Cultural competent care. Service care that respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviors (AHRQ, 2014).

Cultural knowledge. The process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups (Campinha-Bacote, 2002).

Cultural skill. The ability to collect relevant cultural data regarding the client's presenting problem and accurately performing a culturally based physical assessment (Campinha-Bacote, 2002).

Cultural encounters. The process that encourages the care provider to engage in cross-cultural interactions with clients from culturally diverse backgrounds (Campinha-Bacote, 2002).

Cultural desire. The motivation of the care provider to want to, rather than have to, engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters. Cultural desire involves the concept of caring and a genuine passion to accept differences, build on similarities, and be willing to learn from others as cultural informants (Campinha-Bacote, 2002).

Cultural congruence. It is the understanding and application of acceptable beliefs, ideas, and practices that result in an interpersonal, social, and intercultural understanding and acceptance of differences and similarities of all peoples within a worldview (Douglas et al., 2011).

Diversity. The mixture of apparent and invisible psychological, physical and social characteristics, as well as a life experience that affect our views and interaction

with the world, including but not limited to age, culture, immigration status, economic status, economic class, educational experience, ethnicity, gender, language, learning style, location, mental/physical ability, nationality, political affiliation, race, religion, real or perceived gender identity, sexual orientation, and social class (PCAR, 2009). In other words, diversity can be seen as all of the things that make us similar and different. It is also important to recognize our perception of diversity and not minimize or demoralize other's personal characteristics and life experiences (PCAR, 2009).

Ethnoviolence. The violence and intimidation directed at members of ethnic groups that have been marginalized and stigmatized by the dominant or host culture because their inability or unwillingness to assimilate threaten the dominant group's entitlement to society or community resources (Helms et al., 2012).

Intimate Partner, Domestic and Sexual Violence (IPDSV). It is a community and global health issue affecting not only the abuser and the victim but also everyone around them. IPDSV is also not gender-specific.

Violence against women. Any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (WHO, 2016).

Assumptions and Limitations

According to Campinha-Bacote (2009), cultural competence is an ongoing process in which the clinical, behavioral, or social service provider continuously strives

to achieve and maintain culturally sensitive interactions with the client, family, and community. It is a process of becoming culturally competent over time rather than achieving competence as a final goal. The assumptions of the model (Campinha-Bacote, 2002, p. 181) are as follows (a) cultural competence is a process, not an event, (b) cultural competence consists of five constructs: cultural awareness, knowledge, skill, encounters, and desire and, (c) there is more variation within ethnic groups than across ethnic groups (intra-ethnic variation).

In the context of trauma, cultural competence involves the exploration of epistemologies of difference and identity. The first step is to have the privilege or a feeling of ease and safety that comes from knowing that your group is the norm and not targeted because of its characteristics. Privilege contributes to resilience in the face of trauma (Brown, 2009). Another step is to embrace the reality of aversive bias, supported by denial, in the context of race relations. According to Brown (2008, 2009) individuals of good will, especially those working in the clinical, behavioral or social service fields, prefer to view themselves as unbiased and they overtly disavow racism. Addressing the complexities of each person's identity as a factor in trauma response supports strategies to promote resilience (Brown, 2008, 2009). The assumptions of the addressing model state that, (a) people do not have one identity in trauma, (b) observers will construct a person's identity differently than persons construct it themselves and, (c) trauma exposure adds an element of identity that combines vicariously with other variables (Brown, 2009).

Finally, engaging culture in cases of violence helps to shape a victim's

experience and a perpetrator's response to intervention. Warrier (2016) posits that, (a) all cultures include values that are oppressive as well as those that are protective of individuals, (b) each comes into any encounter with cultural experiences and perspectives that might differ from those in that particular system.

Summary

The prevalence of IPDSV is a health epidemic that affects more than one-third of all women globally. Women and children who are exposed to violence are at risk for a wide range of clinical, behavioral, and social health issues. Violence against women also has a high economic cost for society. Root causes must be assessed and changes must be formulated.

Supporting the cultural needs of all is an essential aspect of the approach to trauma-informed care. Culturally appropriate actions must be implemented to address the traditional needs of people, especially in support of their responses to trauma. The process begins with stakeholder leadership, for they will be the agents of change.

Women in the United States are at the mercy of perpetrators who commit horrific crimes. Clinical, behavioral and social service providers, need to take a stance to support all of the past, present, and future survivors in their journey, so that recovery and healing can begin and be sustained. Failure to do so will not only repeat the assault for many of these women, but it can affect the health of their children.

Section 2: Review of Scholarly Evidence

General Literature

Trauma-Informed Care

It is essential to focus on trauma as a core element of health service. The paradigm has shifted from asking survivors, "What's wrong with you?," to "What has happened to you? (SAMHSA, 2014). The traumatic impact of violence not only weighs heavily on the victims, families, and communities but also on the healthcare providers and organizations (SAMHSA, 2014). From an ecological perspective, the intervention targets the larger environment of holistic, systems-level care. One example of an organization that has incorporated the principles of trauma into its care is the Oregon Health Authority. It has evaluated trauma across different ages and population groups (traumainformedoregon.org, 2015). Another facility, the Family Policy Council in Washington State is integrating the research findings of the Adverse Childhood Experiences study and the influence of its results on the health of its communities, including tribal communities (aceresponse.org, 2016).

Preventing revictimization is central to a trauma-informed approach. This fact led to the project question: Will a trauma-informed, culturally competent curriculum be viewed by community stakeholders as an appropriate intervention for the education of their workforce in preventing survivor retraumatization? According to SAMHSA (2014), a victim has three experiences with a traumatic insult: (a) The insult could be a single occurrence or repeated over time. (b) The viewpoint of the occurrence is influenced by the developmental stage of the individual, the availability of support systems, and cultural

beliefs. (c) The victim's preliminary response and reactions to the sequelae of the event vary from short- to long-term.

The best approach to trauma-care delivery is to integrate the three significant components: trauma-focused research work, practice-generated knowledge about trauma interventions, and the lessons articulated by survivors (Guarino et al., 2009). The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed new standards of care using trauma-informed principles. The organization lists implementation domains that guide trauma-informed actions (SAMHSA, 2014, p. 12):

1. Governance is required to oversee this work, namely the stakeholders of the organization. Written policies and protocols that establish a trauma-informed, culturally sensitive approach supports the mission of the organization.
2. The organization needs to ensure that the physical environment promotes the setting as safe, inviting, and culturally sensitive thus minimizing the risk to the physical or psychological safety of the survivors.
3. It is important to engage survivor groups who have a voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.)
4. Multidisciplinary collaboration is essential by forming partnerships within the community.

5. Integrating effective trauma screening interventions should be in place for individuals and families seeking services along with a referral system when services are not available.
6. Trauma-informed and culturally competent principles are incorporated into all aspects of hiring, supervision, and staff evaluation.
7. There should be the ongoing progress of monitoring and quality assurance for sustainability.
8. Financing structures should be in place designed to support a trauma-informed approach, which includes available resources for new staff orientation and continuing education for established staff.

Women-Centered Care from a feministic perspective. The journey to quality improvement for the diverse victims of IPDSV begins with the selection of a nursing-sensitive indicator, namely *Women-Centered Care* (WCC), a human rights-based approach. The basic tenet of WCC recognizes that within the gender-specific culture, women "experience different types of health issues than men and they also experience the same health problems differently than men" (Hills & Mullett, 2002, p. 85). WCC aims to provide policies that support a woman's right to receive care that maintains safety and prevents retraumatization.

A woman loses power and control over her mind and body during the act of abuse. Violence and inequality still resonate in the fundamental fabric of the relationship such as in gender roles and the social sanctioning of male domination despite the illegal act of intimate partner assault (Lawson, 2012). It is the responsibility of the healthcare,

behavioral and social service providers to advocate personal sovereignty. Cultural rights can rationalize activities that discriminate against women and other marginalized groups in a community (Keskinen, 2011). In domestic violence, culture can justify the continuing abuse and oppression of women. Feministic views posit that minority cultures are more sexist than Western culture and thus the women are more at risk for IPDSV. Domestic or sexual violence in the West frequently reflects the behavior of a few deviants rather than the essential part of the culture (Ghafournia, 2014). On the contrary, to associate domestic violence with culture denies the protective role that culture can have in the lives of women (Thiara and Gill 2010, p. 49). According to Smith (2014), all women have an inherent right to, (a) their body and path in life, and to exist without fear, but with freedom. Self- possession and control are unquestioned and honored by others. (b) The authority for self-governance, and the ability to decide on all matters concerning themselves without the need for approval of others. (c) An economic base and resources including the control, use, and development of the resources, businesses, or industries that women choose and finally, (d) a distinct identity, history, and culture. Each woman defines and describes her history, including a worldview and traditional practices for healing and recovery.

WCC considers the woman's desires as the primary focus despite the conventional biomedical model as mainly directed toward a non-gendered approach (McGregor et al., 2009). When managing survivors of violence, certain elements of WCC should be considered; such as the need for safety, recognizing the women's preferences in and when to obtain health care, the need for information while embracing her

participation, insuring social justice and maintaining connections to the community (McGregor et al., 2009).

Specific Literature

Maintaining cultural focus. Health care delivery cannot be all-inclusive without embracing the need for cultural competence. A major barrier to eliminating health care disparities is the lack of reliable race, ethnicity, and cultural data of clients within the clinical, behavioral and social service organizations. Perceived and real barriers that these service groups face include staff reluctance to inquire about the clients' race, ethnicity and language, the perceptions by the staff that disparities do not exist, and the inability of IT systems to accommodate data collection requirements (Rittner, et al., 2010). In light of the change in the cultural composition of the United States, health care providers have the challenge to provide cross-cultural care that is sensitive, effective and meets the needs of the victim and family. Caretakers need to understand the dynamics of the client-clinician dyad such as in the variation in the perception of illness, the diverse belief systems surrounding health, the differences in help-seeking behaviors and the preferred approaches to healing and recovery (Kodjo, 2009). The foundational work by Campinha-Bacote (2002) regarding cultural competence in the provision of healthcare encompasses five constructs; specifically cultural awareness, knowledge, skill, encounters, and desire, which have an interdependent relationship with each other. Being culturally unaware of one's ethnicity about the patient's traditional practices can lead to the imposition of biased values in patient care. Cross et al. (1989) stress the need for a culturally competent system of care, integrating the growth of cultural knowledge at all levels of an

organization, being receptive to the dynamics of cultural differences while modifying health services to address culturally unique needs.

Having a knowledge of an individual's worldview interpretation of their illness can influence the direction of the clinical management and treatment efficacy. Among various cultures, there are common structural factors that shape cross-cultural discourses and analysis of domestic violence. Ethnoviolence is one structural factor directed at diverse ethnic groups. The exposure to race-related trauma may be the primary etiological element in the development of post-traumatic stress disorder (Helms et al., 2012). In the case of intimate partner rape, although the psychological and emotional abuse may occur concurrently, the physical assault is viewed as the primary source of the trauma. If the provider perceives the person of color as arrogant, opportunistic, or hypersensitive, the effect of the original assault is minimized. The provider might not view the traumatic episode as racist or as a violation of the individual's personal being, and the victim is potentially revictimized (Helms et al., 2012).

Performing culturally sensitive skills when assessing a victim after violence supports the recognition of certain indigenous physical attributes on examination. The direct engagement in cross-cultural encounters aids in refining the clinician's perspective when providing care; for example, it will allow the provider to assess the clients linguistic needs to gain knowledge for effective communication. The desire to partake fully in cultural integration must be present to promote receptivity and effect improvement of care (Campinha-Bacote, 2002).

Theoretical Frameworks

The Sanctuary Model

The Sanctuary Model is a theory-based, trauma-informed and evidence supported framework. For a systems-level approach, the framework facilitates the development of structures, processes, and behaviors of the stakeholders, end-users and community as a whole to engage in practices that respond to the wounds experienced by the victims of trauma (Bloom, 2011). The model addresses the dynamics at multiples levels to provide a synergistic context in which healing and recovery are supported. The components of the framework incorporate the *constructivist self-development theory* (aimed to improve the culture of organizations through education), *systems theory* (views the interrelatedness of subsystems to maintain equilibrium), *burnout theory* (the potential for vicarious traumatization or staff exhaustion) and *valuation theory* (to access and understand the deeper interpretations, cognitions and values held by the survivors) (Bloom, 2011; Esaki et al., 2013).

To promote organizational change, the Sanctuary theoretical framework uses a logic model to link activities and outcomes at each socioecological level, namely individual, interpersonal, organization and community (Bloom, 2011; CDC.gov, 2015). An example of a logic model incorporating the components of the socioecological framework for the domestic violence center is presented in *Addendum A.*

Campinha-Bacote's Model of Cultural Competence

This model requires caretakers to "see themselves as *becoming* culturally competent rather than being culturally competent," (Campinha-Bacote, 2002, p. 181). It

serves as a conceptual framework to deliver patient-centered care in the midst of cultural conflict. Campinha-Bacote (2011) has defined cultural competence as the ongoing process in which the clinician continuously strives to achieve the ability and availability to work effectively within the cultural context of the patient (individual, family, and community). The model encompasses the facets of cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters.

Theory of Culture Care Diversity and Universality

The theory of Culture Care Diversity and Universality proposed by Leininger (Leininger, 2002c; McFarland & Wehbe-Alamah, 2015) addresses four components that describe cultural phenomena and offers direction that is culturally sensitive, safe, and valuable for diverse groups in the healing process. Leininger's goal was to create a theory not only for nursing but also to contribute knowledge to other health-related disciplines.

> Culture care expressions, meaning, patterns, and practices are diverse yet there are some universal commonalities among different cultural or ethnic groups. The individual's worldview, social structure factors, ethnohistory, language and professional care are critical components that predict health, wellbeing, illness, healing and the victim's perspectives of disability and death. Leininger (n.d.).

Leininger (2002c) recommended three culture care decision and action modes for caretakers to provide culturally congruent care, stated as follows:

Culture care preservation and maintenance. Provider actions that are assistive, supportive, facilitative, or enabling to help cultures retain, preserve or maintain beneficial care beliefs and values (Leininger, 2002c, p. 84).

Culture care accommodation and negotiation. Provider actions that are assistive, supportive, facilitative or enabling to help cultures adapt to or negotiate with others for culturally congruent, safe, and effective care for their health, wellbeing, or to deal with illness or dying (Leininger, 2002c, p. 84).

Culture care repatterning and restructuring. Provider actions that are assistive, supportive, facilitative or enabling mutual decisions that would help diverse groups to reorder, change, modify, or restructure their life pathways and institutions for improved healthcare patterns, practices, or outcomes (Leininger, 2002c, p. 84).

Section 3: Collection and Analysis of Data

Project Design and Methods

The first step of this DNP project was to examine the demographic data of the current residents at the host organization. The collection and maintenance of accurate demographic data are needed for organizational monitoring, evaluation, and continuous quality improvement activities (Wynia et al., 2011), such as planning intervention programs, improving patient choice, and helping to identify discriminatory practices (Palaniappan et al., 2009) which may induce retraumatization. Organizations may use the data to determine race and ethnicity trends within communities, such as the total number of DV residents requesting language assistance. This information can guide staff assignment decisions because they determine the need for additional language assistance resources at any given time to support culturally specific residents.

This investigation will use the data for the translation of culturally competent principles into practice. More precise identification of the populations at risk are still needed; targeting specific issues based on the data is necessary to apply culturally focused principles. Based on the data, I proposed an educational curriculum and plan for implementation of a pilot program as a future endeavor, provided that the stakeholders of the organization agree. The collection of data will enhance the ability to deliver culturally and linguistically competent services, gauge the degree to which the needs of diverse ethnic groups are being addressed, determine strengths and areas for growth, improve access to services and enabling supports, improve structures and practices, establish and

recognize future meaningful community partnerships, and help to involve the families and communities to promote satisfaction with the services.

Feasibility of the Project

This DNP project is feasible because:

1. The stakeholders and end-users of the organization have expressed a genuine interest and are supportive of implementing culturally competent practices at their organization.
2. The organization is one of the largest shelters nationally that serve more than 8,700 women, men and children annually (Five-Year Strategic Plan, FY2015-2020). Thus, the organization provided sufficient data for analysis.
3. The facility has an electronic health record that is useful for data collection and space was provided by the host organization to accommodate this investigator.
4. This investigator has completed the NIH Human Participation Protections Education for Research Teams as required before the data collection process.
5. IRB approval was obtained and the approval number for this study is 08-16-16-0445763.

Population and Sampling

I was given existing secondary data for the first quarter of 2016 by the Chief Executive Officer. The total number of adult residents was 512, and the total number of children was 258. The information required for collection includes the demographic data in *Table I.*

Data Collection

The CEO and Chief Operating Officer (COO) had approved the data analysis, both of which followed procedures for confidentiality in compliance with HIPAA. All data collected was maintained within the security network in an encrypted password protected file on the DV center system. Data extraction was performed at the site before my involvement, by the Director of Quality Assurance, Research, and Evaluation thus assuring validity as a source of data. The Director's position includes,

- Developing and establishing departmental structure and activities to facilitate the organization's use of data in decision-making on multiple levels (For example, programs, funding), implementing a philosophy of Continuous Quality Improvement (CQI) and an Internal Review Board (IRB) for research.
- Utilizing data to improve existing programs and inform work; defines the strengths, weakness, opportunities, and threats of the current data, collection strategies, and evaluation.
- Developing strategies for collecting additional data (intake, interviews, focus groups, etc.) including researching, identifying and recommending appropriate software to track best and measure goals and objectives.

Any report or presentation of the analysis had all personal health information de-identified.

Table I

Data Collection Groups

Demographic data	Segmentation variables
Age of resident	0-17, 18-29, 30-44, 45-59, 60-64 (Elders), > 65
Gender	Female, Male, Transgender
Race	Caucasian, African-American, Asian, Native American/Alaska Native, Native Hawaiian/other Pacific Islander, Other
Ethnicity	Hispanic, Latino or Spanish origin, Non-Hispanic, Latino or Spanish origin or other

There was no direct patient contact and no individual consents obtained. Gathering information on patient demographics provided an understanding of some issues and is critical to meeting the needs of the residents at the DV organization.

Data Analysis

A descriptive analysis was performed to determine the variation of the age, gender, cultural and ethnic groups of the residents within the DV organization. The SPSS program was used for analysis. Median values were calculated using the groups of data that contain ordinal variables, as in the age group. Bar graphs were used to display the data. The groups of data that are categorical are shown in the form of pie and bar charts.

Project Evaluation Plan

I enlisted the opinions of one stakeholder from the Indian Health Service, in the evaluation of this DNP project. I have discussed the results of the evaluation by the

stakeholder in the following section. The aim was to elicit support, guidance, and recommendations that will refine the purpose, process, and outcome of this project.

Summary

This DNP study involved a demographic assessment to obtain a more precise identification of the populations at risk. It will help to target the specific issues based on the data for the translation of culturally focused principles into practice. As a post-doctoral endeavor, the data will guide recommendations for improvement to reduce retraumatization in the survivors of domestic violence organizations.

The evidence has proven the impact of trauma on the short and long-term health of all those affected by violence. We need to as a nation, work towards providing and safeguarding protective equity for survivors of all cultures, races, and ethnicities. If we do not, then we would have failed our loved ones and those loved by others, in the cultural context of their being.

> *The need is still there, and so are the victims.*
>
> *To care for someone, I must know who I am.*
>
> *To care for someone, I must know who the other is*.
>
> *To care for someone, I must be able to bridge the gap between myself and the other.* (Jean Watson, n.d.).

Section 4: Discussion and Implications

Summary and Evaluation of the Findings

In this section, I present the data analysis, a description of the populations, a summary of the findings, and their applicability in the context of the literature. I will discuss the implications for practice and social change. Finally, I will review the strengths and limitations of the project and assess my skills as a scholar, practitioner, and project developer. The purpose of this project was to develop an educational curriculum to train the workforce at the organization, to become culturally aware and culturally competent and to prevent the survivors from retraumatization while entrusted in their care.

Age

A descriptive analysis was used to determine the variation of the age, gender, culture, and ethnic groups of the residents within the organization. The SPSS program was used for analysis. The demographic variable of age was analyzed for both women (n = 187) and children (n =156) as shown in the Figures 2 and 3. Most women were within the median age group of 30-44.

The children's data is shown in Figure 3. Most children at the Genesis organization were between the ages of 6-12.

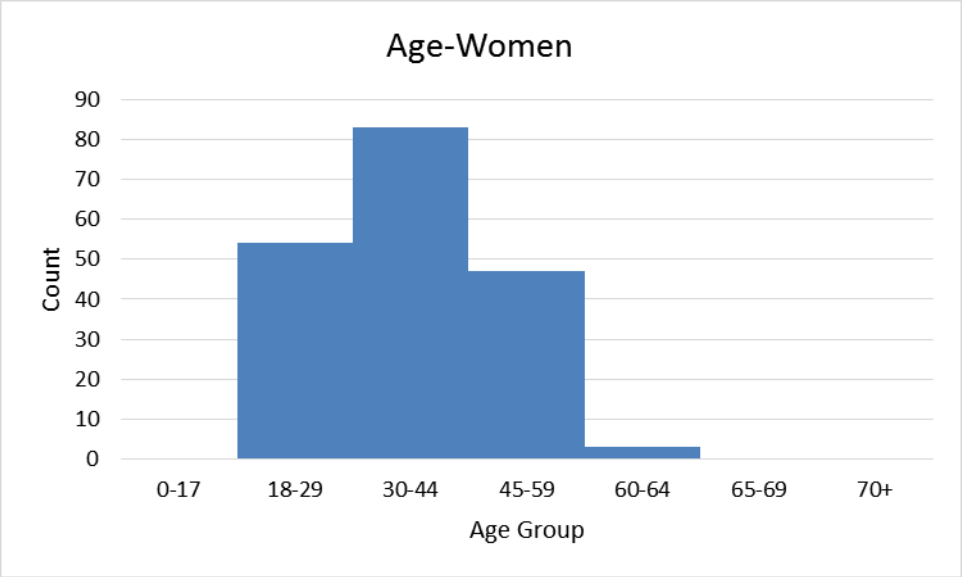

Figure 2. Age groups of women at the host organization.

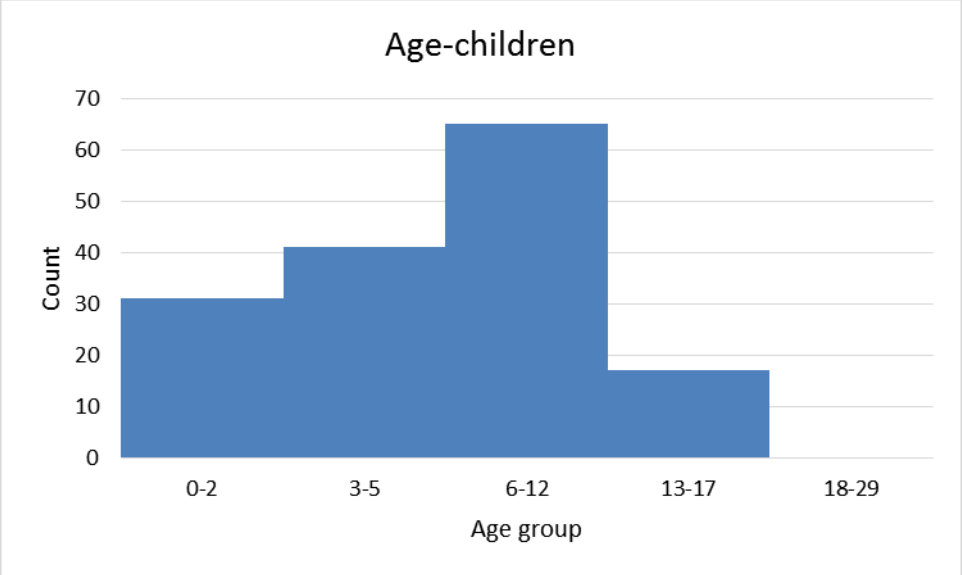

Figure 3. Age Groups of Children at the DV Organization.

Gender

Regarding gender, figure 4 shows the numeric differences in the gender of both adults and children. One analysis is the number of new adults upon intake versus the

adults carried over into residential placement. The figure shows that for the first quarter in 2016, there were 233 new women upon intake versus three men. Regarding residential placement, there were 267 women placed versus nine men. Within the children's' population, there were 38 new girls versus 45 new boys. However, 66 girls were carried over and placed versus 62 boys.

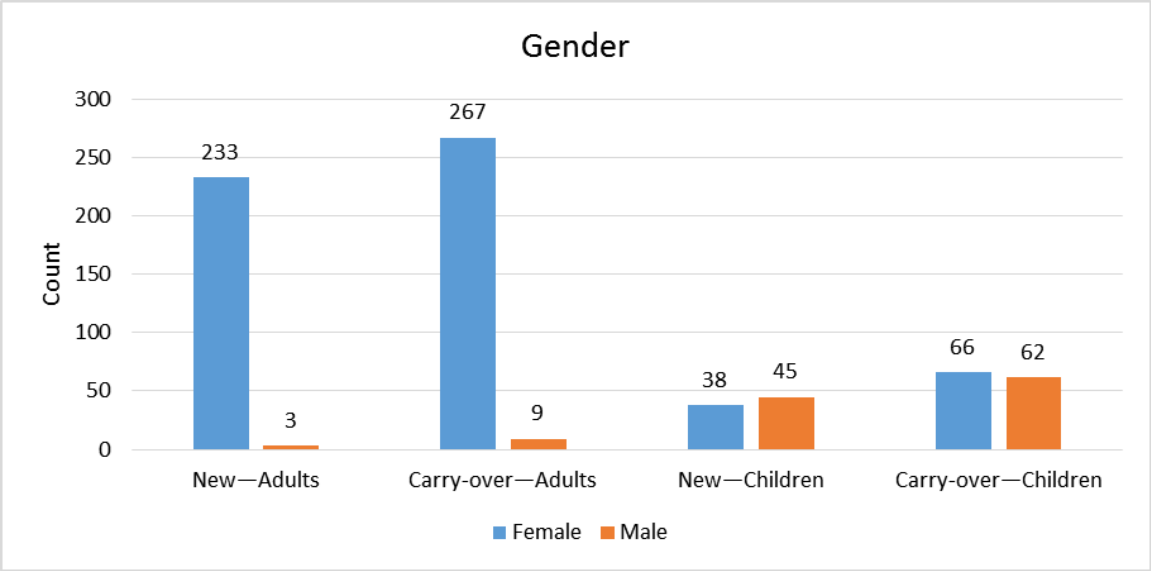

Figure 4. The number of gender differences between female and male residents.

Race

The diverse racial groups (Adult *N* =512; children *N* =258) are delineated in *figure* 5. The three dominant resident groups noted are (a) Caucasians (*n* =213), (b) Hispanics (*n* =124), and African-Americans (*n* =87). In the children's population, the three dominant groups are (a) Caucasians (*n* =120), (b) African-Americans (*n* =48), and (c) other (*n* =40, not specified but not mixed).

Ethnicity

The breakdown by ethnicity involves Hispanic versus not-Hispanic numbers in both adults (*N* =512) and children (*N* =217). As shown in *figure* 6, there were 253 Hispanic adults or 49% of the population versus 259 non-Hispanic adults or 51% of the total population.

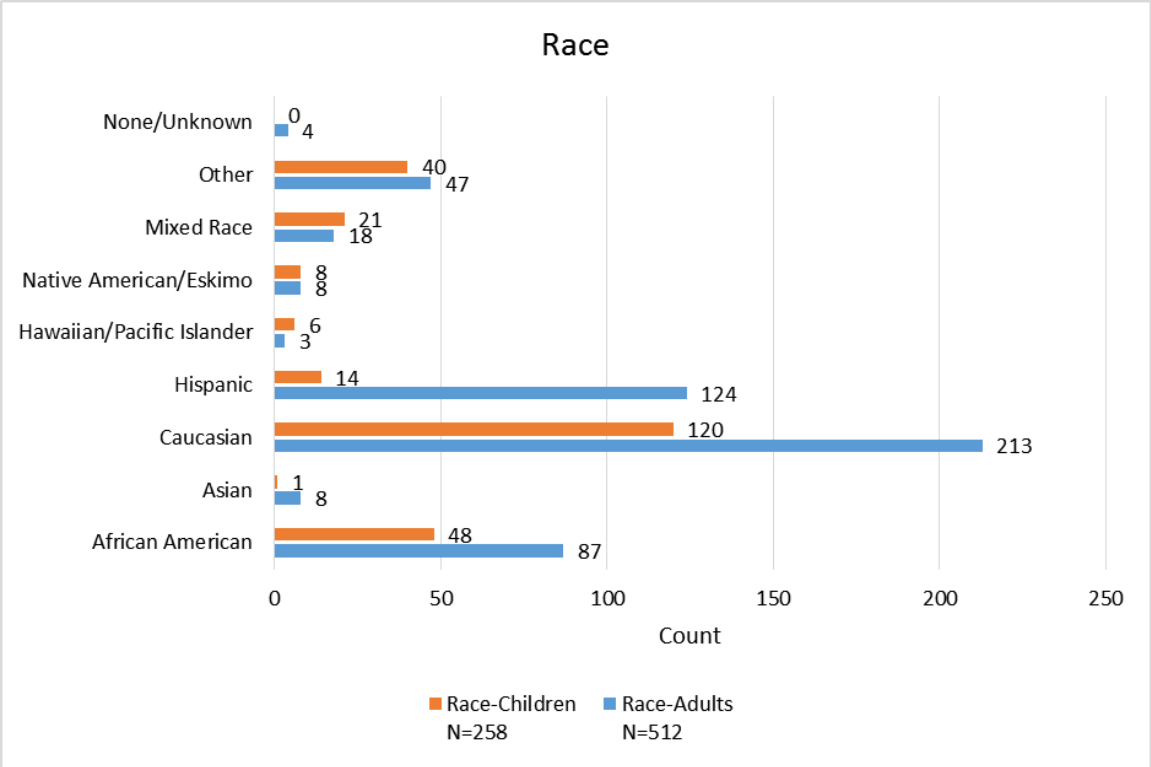

Figure 5. The numbers of residents by racial groups at the host organization.

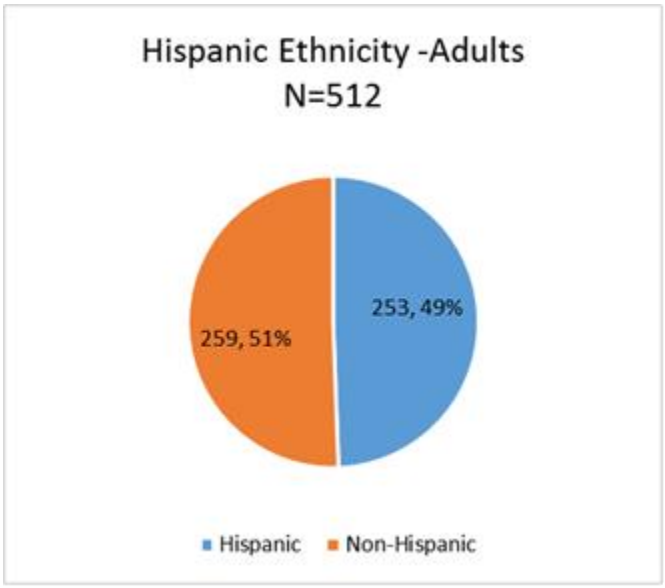

Figure 6. Hispanic ethnicity in adults and children.

The children's' numbers are displayed in *figure* 7. There were 107 Hispanic children or 49% versus 110 non-Hispanic children or 51% residing in the DV organization.

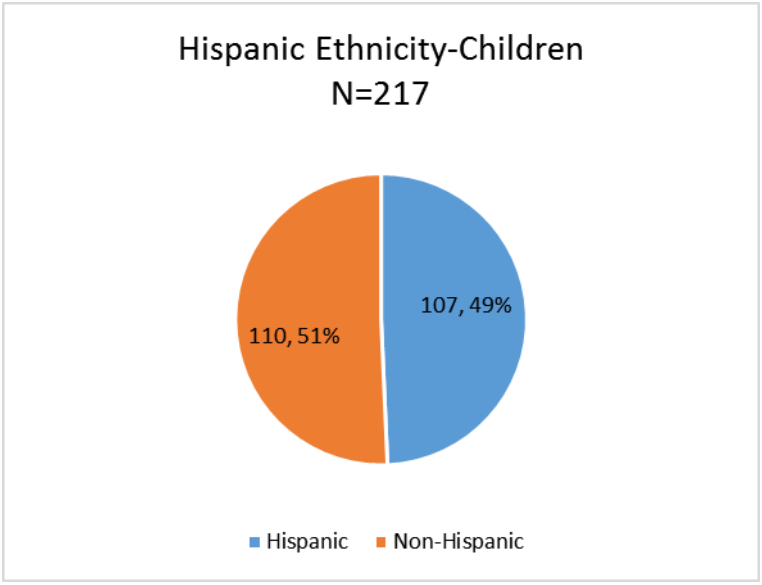

Figure 7. Non-Hispanic ethnicity in adults and children.

Discussion of the Findings in Context of the Literature and Frameworks

Although, I was unable to perform the data collection in the manner of which I would have preferred, the findings suggested in this organization as in many others, that women and children presented as the majority affected by violence (Mallicoat & Estrada Ireland, 2014). Most of the residents were in the early to middle age range with children averaging between 6-12 years of age. Most of the DV population included Caucasians followed by Hispanics and African-Americans, and the racial makeup of the children was similar except 'other, not specified' in third place. The Hispanic population presented as almost half of the overall population.

Even though there were more Caucasians than other racial groups residing at the Genesis organization, I was unaware of their cultural background. In other words, the need for culturally competent practice remains an important component when managing the victims of violence. As Brown (2009) stated, individuals do not have just one identity in trauma, and furthermore, there may be more dissimilarities within ethnic or cultural groups than across these groups (Campinha-Bacote, 2002).

Implications for Practice and Social Change

I enlisted the input of a stakeholder to evaluate my completed educational curriculum. I decided to invite the opinion of Dr. Kimberly Couch, the Director of the Women Infants Service Line (WISL) at the Indian Health Service (IHS) in Phoenix, Arizona. I approached her, and we had a conversation.

After the review of the curriculum, she focused her comments more on the direction of the content of the education. First of all, when considering the rationale,

context, and definition of cultural competence, Dr. Couch expressed that the concept of cultural competence along with other associative definitions was delineated well within the document. There was also a clear sense of the author's self-assessment and reflection. Dr. Couch felt that the key epidemiological aspects of the concept was clarified well as in the presentation of cultural diversity locally and nationally. Although the document did not provide a discussion of the specific values, beliefs, and practices of each cultural group, the Director understood the rationale of the need to learn more about the individual worldview in the provision of culturally competent care. Dr. Couch understood the potential for institutional revictimization after trauma thus, addressing the aim of this project.

Focusing on provider bias, stereotyping, discrimination and racism were deemed necessary by the Director, who appeared pleased that these sensitive topics were being addressed. Finally, Dr. Couch felt that the curriculum imparted vital information on the performance of skills such as a culturalogical assessment when engaging in a medical and social history, having the capacity for patient adherence and communication skills. Overall, the discussion progressed well and Dr. Couch confirmed that the content of the project was appropriate for the research question and the goals at hand.

The implication for practice still applies as stated in Section one of this document. The purpose of the data collection and analysis was not to negate or confirm the need to develop the plan of this project. The intention was to gather knowledge on the cultural and ethnic variation to inform the direction of culturally competent education. However, as I proceeded through the examination of the literature, frameworks, science and the

opinions of scholars, I came to a realization that the whole purpose of cultural competence is to connect with and listen to the cultural informant that is in the person you are caring for, nothing more.

Project Limitations and Strengths

There are two limitations of this project. The first limitation was my inability to gather data on a deeper level. The restriction placed on my request for direct engagement in data collection was unfortunate. The project would have benefitted from additional information related to administrative, workforce and organizational processes. Secondly, in light of the subject matter, the ability to discourse directly with survivors would have been an asset and a profound influence on the direction of the project. Listening to the stories and eliciting the opinions of survivors is vital and should not be minimized. The survivors of violence contribute greatly to our knowledge as service providers.

The strengths of this project are multifold. The document is a hearty conglomeration of research, science, theories, frameworks, scholarly and documented survivor opinions. The development was an iterative process that unfolded over a period of four years. The journey encompassed many struggles with pursuing knowledge, getting approvals, dealing with delays and managing conflicts. I have been angered, saddened, aggravated and yet joyful, pleased, and relieved by this project. I can look upon this work as did the Supreme being when he saw his creation of the world on the seventh day and felt that all was good (Genesis 1), so he rested, and now so can I.

Analysis of Self

As a Scholar

I understand that in the 23 years of being a Midwife, I was already a scholar in the area of birthing babies. However, since I entered this program, I realize now that I am a different kind of scholar. I have expanded my horizon to include areas of Women's health that creates a feeling of discomfort to most of the general population. I have developed an academic poise in how I approach research and inquiry. I feel authoritative in that I have reached a comfort level, speaking on the topics with confidence within my specialty. My colleagues have recognized my work and have approached me more frequently, needing advice, or presenting me with questions on clinical practice regarding the topic. Finally, I feel like I have become more passionate about the type of work that I do and take a strong stance on it. It is a nice feeling of achievement.

As a Practitioner

In the area of clinical practice, I have never felt at a disadvantage. I always viewed myself as one of those individuals who is fully capable of providing competent bedside care and possessing good hand skills. I had an aptitude for translating knowledge into practice even before entering the DNP program. Thus, there are no concerns when examining myself as a practitioner.

As a Project Developer

I enjoy developing projects but never have I developed such an intensive project like this DNP paper. It was quite a rite of passage. I plan to continue working on projects

within the Indian Health Service after graduation, but I will be hesitant about taking on another venture of this enormity.

Plan for Future Professional Development

Since I am an employee of the Indian Health Service, my plan for self-development is in alignment with meeting the needs of my patient population, the American Indian/Alaska Native community. After taking a little reprieve, I will develop and implement a trauma-informed process within the Women Infants Service Line division to address the current standard of care in managing the survivors of IPDSV. If all goes well, then I will continue to take small steps in implementing the process organization-wide. I understand that this venture may take many years before it becomes a true organizational culture change. However, someone needs to embark on the journey, and I feel qualified to do so.

Summary

The short- and long-term sequelae of domestic and sexual violence on survivors and the potential for revictimization in their daily lives are well documented. Trauma-informed principles provide insight to interventions that are designed specifically to address the sequelae of trauma. One such intervention is the inclusion of cultural influence. Culture can play a role in a survivor's response to trauma, or it may be the precipitating factor leading to trauma.

To understand survivors of diverse cultures, it is essential that service providers examine their biases and engage in continuous efforts to appreciate their clients within the cultural context of their being. Our modern world is colonized by multitudes of acculturated and enculturated populations representing a complexity of diversity. The collection of demographic data and the learning of values, beliefs, and practices of cultures alone are insufficient. When we, as service providers, care for the traumatized, we must reach out and be informed by the individual worldview. Only then, we can rest assure that we are taking the right direction to contribute to the healing, empowerment, and resilience of the survivors.

Conclusion

Let it be known that this project is of my heart, soul, sweat, and tears. Please take the time to read it, hear it, understand, and learn from it. As Professor Norman (Morgan Freeman) said to Lucy (Scarlett Johannsen) in the film, *Lucy* (2014), when she was wondering what to do with all of her newfound knowledge, Professor Norman (Freeman) stated,

> This whole purpose of life has been to pass on what was learned. There is no higher purpose. So, if you're asking me what to do with all this knowledge you're accumulating, I'd say, pass it on. (Lucy, 2014).

Thus, when you have completed your read and feel that you have reached saturation, I encourage you to please pass it on to your loved ones, your children, and all those that may benefit from the message. Thank you.

Section 5: Scholarly Project for Dissemination

Please find the enclosed unpublished manuscript, *Implementing Cultural Competence to Support Trauma-informed Care, Developing Culturally Competent Practices at Domestic Violence Organizations to Prevent Retraumatization in Diverse Cultural Groups and Guidance to the Path of Resilience* [Participant Workbook for the DV Workforce] by Luana Rodriguez, MSN, CNM, SANE. The manuscript is in Appendix B in this document.

I believe the findings would appeal to the medical, behavioral health, and social service communities in the care and support of diverse survivors of intimate partner, domestic and sexual Violence (IPDSV).

I confirm that this manuscript has not been published elsewhere.

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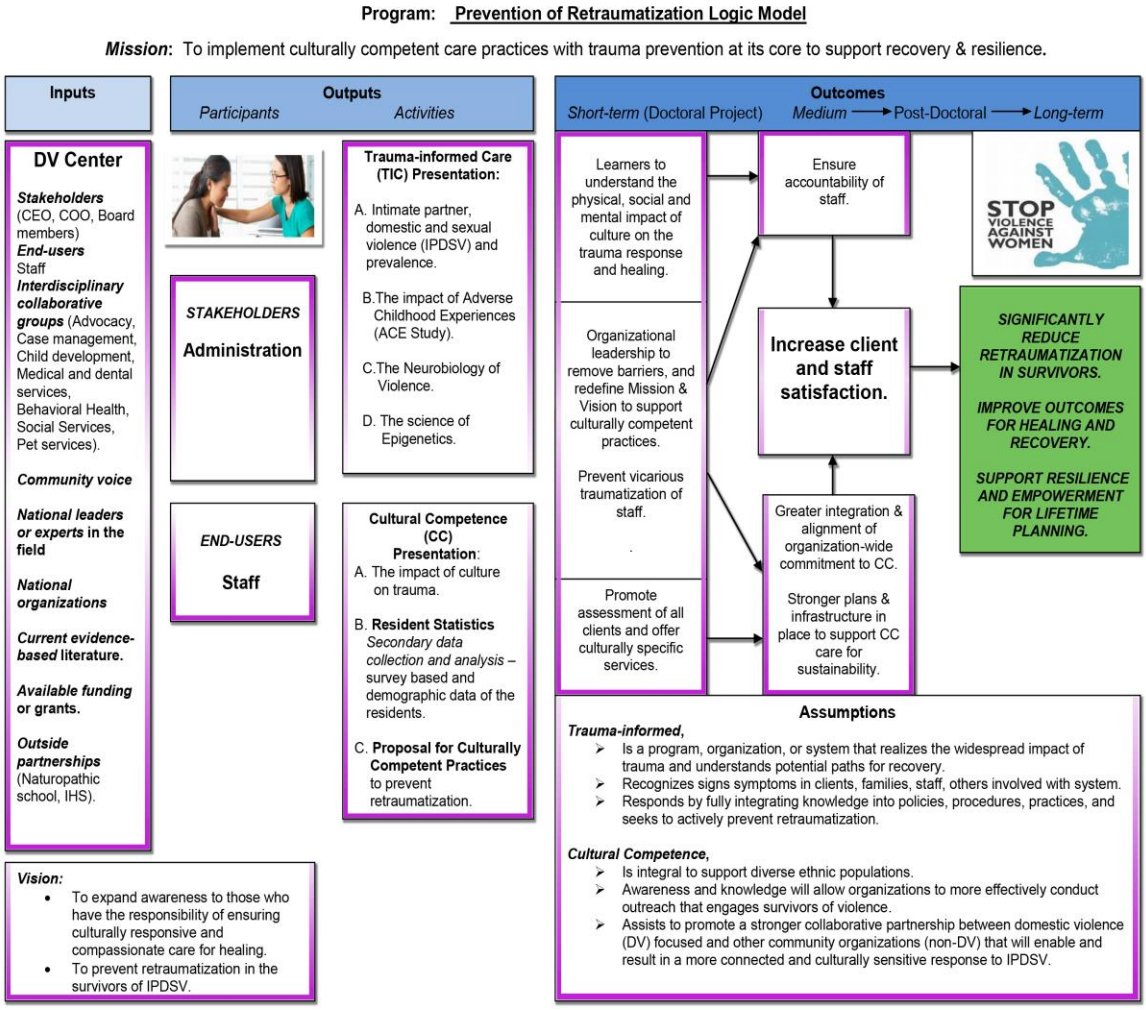
Appendix A: The Domestic Violence Logic Model



Appendix B: Scholarly Project

Implementing Cultural Competence to Support Trauma-informed Care

Developing Culturally Competent Practices at Domestic Violence Organizations to Prevent Retraumatization in Diverse Cultural Groups

and

Guidance to the Path of Resilience

[*Participant Workbook for the DV Workforce*]

by

Luana Rodriguez, MSN, CNM, SANE

Project Submitted in Partial Fulfillment

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Background

What does our future hold in a world afflicted by violence? Each year, millions of men, women, and children globally, have endured acts of abuse, neglect, and maltreatment, the majority of which is by the hands of those closest to them. The victims trust that their service providers will heal their physical injuries, wounded psyches, and hearts; many of whom have experienced severe and repeated acts of cruelty. The unaddressed psychological and physical effect of these adverse experiences, especially early in life, have shown a connection to many social, emotional, and cognitive impairment, chronic health conditions, using high-risk behaviors as ways of coping, with an increased risk of early death (cited by Rodriguez, 2016).

Historically, the impact of trauma was either not taken seriously or viewed as a valid source of suffering (cited by Rodriguez, 2016). The inflexible rules, lack of confidentiality and practices that place the victim at blame in traditional healthcare and social service systems may provoke feelings of being revictimized (cited by Rodriguez, 2016). Otherwise, trauma is of greatest importance when searching for a solution to deal with human distress for those who are aware and understand its impact (cited by Rodriguez, 2016). Staff members may be doubtful and resist practicing trauma-informed care because they may not know enough about the impact of trauma, are unsure of how to respond effectively or even may have some concerns about their past or current history of trauma (cited by Rodriguez, 2016).

The Curriculum

The goal of the curriculum is to have the staff at DV organizations acquire knowledge on trauma-informed practice, cultural competence and their role in promoting resilience. The curriculum targets the workforce at domestic violence (DV) organizations and focuses on the development of skills and expansion of knowledge through didactic and interactive activities.

The Curriculum

- The curriculum includes a participant workbook for reference during the seminar.
- There are three modules on the evidence, cultural competence, and resilience with an addendum on vicarious traumatization.
- The curriculum may be presented as a one-day seminar or two half-days presentations. Each module has learning objectives.
- Depending on the module, there may be videos, handouts, or activities for trainee participation.
- The length of the time allocated for the activities will vary depending on the material presented and the degree of participation.

Intended Audience

This curriculum has been prepared for all staff at domestic violence organizations including leadership, administrative support, frontline, and direct care staff.

Mission of this Curriculum

To educate the DV workforce on culturally competent care practices with trauma prevention at its core to prevent retraumatization and promote resilience.

Vision of this Curriculum

We envision a world in which all culturally diverse survivors of violence know they are believed, safe, and supported by the hands and hearts of those responsible for ensuring their physical, mental, and social well-being.

The Goal of the Training

The purpose of this training is to help the learner understand how becoming culturally competent will improve skills to address trauma experienced by diverse survivors of domestic and sexual abuse. Cultural competence is a critical step of trauma-informed practice, a forerunner leading to the path of resilience. The approach is best implemented by changing conventional health and social care systems to be responsive to the needs of diverse populations (Betancourt, 2005) shown as follows:

1. The need to encourage the development of a culturally proficient and diverse strategic plan.
2. The importance of implementing intervention by initiating education for the DV workforce in the format of a training curriculum that is racially, ethnically, and culturally diverse and competent.
3. The necessity to integrate the use of initiatives that is manageable, measurable, and sustainable.

Important Considerations for Participants

In light of the high prevalence of domestic and sexual violence universally, there may be individuals that have experienced violence and may be triggered by this presentation. Please be cognizant and offer support to participants that appear to be experiencing difficulty with the material. Inform the presenter as if additional breaks are needed or a time for debriefing.

Training Site

The program will be presented at the local domestic violence organizations.

One-Day Agenda

8:00–8:30 am Registration

8:30–8:45 am Welcome

8:45–10:15 am *The Evidence Speaks*

10:15–10:30 am Break

10:30–12:00 pm *Cultural Competence*

12:00–1:00 pm Lunch

1:00–2:30 pm *Resilience* in Adults and Children

2:30–2:45 pm Break

2:45–3:45 pm *Vicarious Traumatization*

3:45–4:15 pm Closing, Questions, and Evaluation

Introduction

Why Learn About Cultural Competence and Trauma-Informed Care?

Intimate partner, domestic and sexual violence (IPDSV) involve personal acts of shared physical and social realities, and frequently of shared or overlapping cultures and meanings (cited by Rodriguez, 2016). Improving cultural competence is a key step in effectively addressing the experience of trauma. Culture is an important part of a person's identity and to the process of grieving, expressing pain, fear, and healing (cited by Rodriguez, 2016). Learning about culture will give you a better understanding of how to connect with the survivors, appreciate the events of their trauma while supporting recovery, resilience, and empowerment.

Trauma interacts with a unique set of experiences that each person carries within and brings to their encounter with painful, disruptive events and forms (cited by Rodriguez, 2016). Even the best programs will not be effective if cultural competence is not integrated into a trauma-informed solution (cited by Rodriguez, 2016). It is important that DV staff members understand and examine the meaning of their identities and biases when considering the effect of trauma, and in planning healing strategies for the survivors (cited by Rodriguez, 2016).

> Trauma is trauma is trauma. The texture of pain, the color of fear, and the melodies of cries are all human and shared. They are all uniquely configured, and ordered by human identities, cultures, heritages, and networks of relationships (cited by Rodriguez, 2016).

Cultural competence within organizations has shown to improve health and social outcomes for those affected by IPDSV (HRETdisparities.org, 2013). The various benefits are delineated in Figure 1.

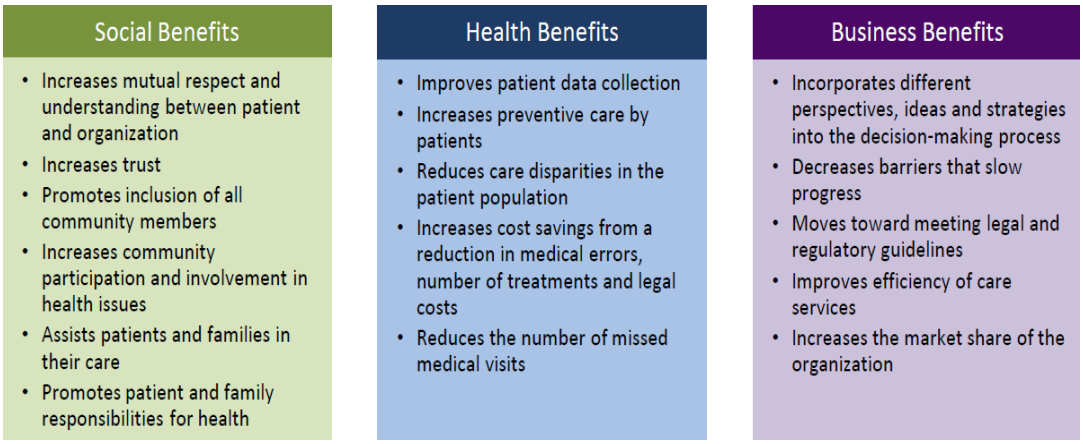

Figure 1. Benefits of becoming a culturally competent health care organization. Retrieved from the American Hospital Association (AHA.org, 2012).

What is Trauma-Informed Care?

Trauma-informed care provides a foundation for understanding and being receptive to the negative effects that trauma has on the physical, psychological, emotional, and social health and safety of survivors. Knowing the impact of trauma helps us to create opportunities to support the survivors in maintaining a sense of control and becoming resilient (Hopper, Bassuk, & Olivet, 2010). Victims, families, service providers and communities are all affected by trauma (SAMHSA, 2014). The question for survivors is changed from, *"What's wrong with you,"* to *"What has happened to you?* (SAMHSA, 2014).

What Occurs When a Survivor is Retraumatized?

Survivors that are repeatedly exposed to trauma or to events that trigger adverse memories, namely sights, sounds, smells, location, or in the presence of specific individuals is referred to as retraumatization (SAMHSA, 2014).

Staff and organizational issues that can cause retraumatization include (SAMHSA, 2014)

- Treating clients without screening for trauma.
- Disbelieving or minimizing reports of trauma.
- Involving the survivor in activities that are humiliating.
- Challenging or interrogating the client during counseling.
- Ignoring the presence of abusive behavior of one individual against another without intervening.
- Categorizing certain survivor reactions or behaviors as abnormal or used as an example of ridicule.
- Lack of safety and security within treatment or residential organizations.
- Not engaging the input of survivors when care planning.
- Interrupting the continuity of care with the client's preferred relationships.
- Invading client privacy.
- Demonstrating inconsistency in adhering to organizational rules and policies without considering the opinion of the survivors.
- Limiting access to services for culturally diverse populations.

How do we Prevent Retraumatization? (SAMHSA, 2014)

1. Consider the needs of traumatized survivors when developing program policies and procedures in residential settings that might trigger memories of trauma.
2. Be receptive to the adverse experiences of the survivors. Disregarding the clients' reactions when they are triggered, exacerbates the intensity of the responses rather than reduces them. It is important to observe and listen to what appears to be the trigger.
3. Based on the survivors' history, it would be best to develop an individual coping plan and have the survivors rehearse in advance to prepare for situations when they are triggered.
4. Acknowledge that certain clinical efforts to control the survivors in treatment or residential settings can be a form of revictimization, especially if the traumatic experience involved *being trapped* in some manner.

The Principles of Trauma-Informed Care. The Implementation of Trauma-Informed Care (TIC) Helps to Avoid Retraumatization by:

1. Understanding that many problem behaviors begin as attempts for the survivor to cope.
2. Supporting empowerment and resilience of the survivor in the healing process.
3. Teaching community leaders to support survivors, and to *condemn victim-blaming*.
4. Building systems that are gateways, not barriers, to services.

According to SAMHSA (2014; cited by Rodriguez, 2016), three events occur when a victim encounters a traumatic experience:

1. The initial *insult* may be a single occurrence or repeated over time.
2. Secondly, the *experience* of the event is influenced by the age or the developmental stage of the individual. The availability of support systems and cultural beliefs are also very important.
3. Finally, the person's *response* and the duration of the symptoms in survivors may vary from short to long term.

Trauma-informed care supports a collaborative paradigm for different groups and organizations to partake in for the common good. It creates a "ripple" throughout the fabric of healthcare affecting all systems. As the concept of trauma and its potential short and long-term consequences continue to emerge, service providers will respond effectively in joint efforts to prevent violence and retraumatization. Trauma-informed care is an approach where everyone has a role to play (cited by Rodriguez, 2016).

What Does the Data Show?

The prevalence of IPDSV in the United States is a serious public health concern. The most recent National Intimate Partner and Sexual Violence Survey data collected by the U. S. Centers for Disease Control and Prevention reported that:

- One in three or 30.3% of women in the United States is physically assaulted, or stalked by an intimate partner (cited by Rodriguez, 2016).
- Approximately 3.2 million women in the United States experienced severe physical violence by a close partner in their lifetime, which means one in four

women or 24.3% in the year 2010. In other words, about 20 people per minute are affected by IPDSV in the U.S. (cited by Rodriguez, 2016).

Sexual Violence

Sexual assault against women is one of the most widespread human rights violations. Sexual abuse presents in several ways, through intimate relationships, by family members and at the hands of strangers. According to the National Incident-Based Reporting System (cited by Rodriguez, 2016), 346,830 total women were sexually violated in the United States alone. Sexual violence encompasses (cited by Rodriguez, 2016):

- Sexual harassment or force.
- Unwanted sexual contact.
- Non-contact unwanted sexual experiences.
- Rape involving penetration.

Sexual abuse can occur without a victim's consent when a victim is unable to consent (due to age, illness, or mental incapacity) (cited by Rodriguez, 2016) or when a victim refuses (due to physical violence or threats) (cited by Rodriguez, 2016). The statistics show that:

- One in five women have experienced an attempted or completed rape in their lifetime, defined as penetrating a victim by use of force or through alcohol or drug facilitation.
- Nearly one-third of women (32.1%) experienced some non-contact unwanted sexual experience in their lifetime (cited by Rodriguez, 2016).

- The research shows that women are victims of sexual violence in 95% of these cases (cited by Rodriguez, 2016).

How are the Children Affected?

The impact of domestic violence on children is a statistic that speaks for itself. The most recent percentages show that there were (cited by Rodriguez, 2016):

- Almost 7% of U.S. children exposed to physical violence, which is more than 5 million children.
- Approximately 1% or almost one million children exposed to serious violence, for example, kicking, choking, and beating.
- Roughly 5.7% affected by psychological or emotional violence, or about 4.3 million children.
- Exposure to physical or psychological violence between adults or adult and teen (any family violence involving an adult), affects 11.1% equating to 8.3 million children.

Being exposed to intimate partner violence (IPV) is distressing to children and is connected to a host of mental health symptoms both in childhood and in later life (cited by Rodriguez, 2016). The experience most likely to place children at risk is *eye witnessing*, which accounts for 65 to 86% of all exposure (cited by Rodriguez, 2016).

How About Arizona?

Arizona statistics. Arizona is a diverse state, consisting of not only urban, suburban and rural areas but also 25% of tribal land. The largest city in the state is Phoenix, which also is the sixth largest city in the United States comprising of 1.4 million people in 2014 (cited by Rodriguez, 2016). Maricopa County, within the Phoenix area, accounts for 60% of the total Arizona population.

In the State of Arizona.

1. One in four women experience domestic assault in their lifetime.
2. One-third of the women are victims of violence-related homicides committed by intimate partners (cited by Rodriguez, 2016).
3. For the year 2014, 2,445 cases of rape were reported which translates to one rape committed every three hours and eighteen minutes (cited by Rodriguez, 2016). Due to the problem of underreporting in many cases, the statistics may not reflect the true incidence of sexual victimization (cited by Rodriguez, 2016).
4. In a statement submitted by the Arizona Criminal Justice Commission (cited by Rodriguez, 2016), the overall rate of rape nationally between the years 2004-2013 decreased from 32.2 to 25.2 per 100,000 (cited by Rodriguez).
5. However, during that same time, the rate of forcible rape increased in Arizona from 33.0 per 100,000 to 35.4 per 100,000.

Question. Why do you think that Arizona rates of rape are higher than the national rates?

PowerPoint Slides. To be developed (TBD) post-doctorally.

MODULE 1: The Evidence Speaks

Learning Objectives

- Understand the story behind the ACE Study?
- Associate the results of the ACE study with its impact on overall health.
- Recognize the neurobiological sequelae resulting from the trauma of sexual abuse.
- Discuss the consequence of trauma on intergenerational health.

The ACE Study

What is your awareness of the ACE Study?

- No knowledge
- Some knowledge
- More than most others
- Expert

The Adverse Childhood Experiences (ACE) study was developed by Dr. Vincent Felitti, a Bariatric physician from San Diego and Dr. Robert Anda from the Centers for Disease Control. They discovered a link between early childhood maltreatment and adult health issues. The findings started the largest research study ever conducted to investigate these connections. More than 17,000 Health Maintenance Organization (HMO) patients, mostly White, middle, and upper-middle class, and college-educated, revealed detailed information about their childhood experience of abuse neglect, and family dysfunction neglect (Sadler-Riggleman & Skinner, 2015). The findings of the study contributed to the development of trauma-informed care, and a global movement initiated to address the

consequences of lifetime trauma. The results of the studies suggested that these experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States (acestoohigh.com, 2015).

Why is Understanding ACEs so Important?

Understanding the connections will improve effort towards prevention and healing that involves research, practice and survivor knowledge to manage trauma (SAMHSA, 2014). The researchers have discovered the following (Felitti, et al., 1998):

- ACEs are Common. Nearly two-thirds (64%) of adults have at least one ACE. If any one ACE is present, there is an 87% chance that at least one other ACE is present, and 50% chance that three others are present.
- ACEs are associated with adult-onset chronic disease, such as cancer, heart disease, mental illness, in addition to violence and being a victim of violence. Individuals are more at risk for adverse health conditions as the number of ACEs increases (ACEsTooHigh.com, 2016).

An ACE score of four or more predisposes individuals to(ACEsTooHigh.com, 2016):

- Chronic pulmonary lung disease with an increase of 390%.
- Hepatitis with an increase of 240%.
- Depression is increased by 460%.
- Suicide increased by 1,220%.

With an ACE score greater than 6, the likelihood of,

- Becoming an IV drug user increases 4,600%,

- Dying on the average of 20 years earlier than those with low ACE scores.

The exorbitant costs in health care, mental health, and the criminal justice system result from the high prevalence of the population affected by their adverse childhood (ACEs). In fact, it has been discovered that the ACE most responsible for many of today's chronic illnesses are that of childhood adversity (Felitti et al., 1998).

The Components of the ACE Questionnaire and Scoring

Two Categories of ACEs.

Abuse or Neglect.

- Recurrent physical abuse.
- Recurrent emotional or verbal abuse.
- Sexual abuse.
- Emotional or physical neglect.

Household Dysfunction.

- A parent who is an alcoholic.
- Incarcerated household member.
- Someone who is chronically depressed, suicidal, institutionalized, or mentally ill.
- A mother who is a victim of domestic violence.
- The disappearance of a parent through divorce, death, or abandonment.

***Example*.** Each adverse experience counts as one. Thus, a person who had been sexually abused as a child, whose mother was diagnosed with schizophrenia, and when the child was at 14 years of age, the mother committed suicide, will have an ACE score of three.

PowerPoint Slides. TBD.

Handouts. See Adult and Pediatric ACE questionnaires in Addendum A.

Activity. Take the 10-question survey and calculate your ACE score. Knowing your ACE score, *what would you do with the results*?

Video. How childhood trauma affects health across a lifetime (16-minute TED Talk by Dr. Nadine Burke Harris). Retrieved from http://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime#t-622453.

Dr. Nadine Burke Harris Bio. Dr. Burke Harris became the founder and CEO of the *Center for Youth Wellness*, an initiative at the California Pacific Medical Center Bayview Child Health Center. The center has created a clinical model to recognize and effectively treat toxic stress in children.

The Neurobiological Response to Violence

Early social and emotional experiences are important to the developing brain. The human brain is extremely flexible and adaptable, particularly in early childhood. A certain degree of *stress* on a person is considered healthy. Stress is always present in our lives and can be an effective teaching tool as one learns to manage and persevere through difficult experiences (Campbell, 2012). Stress can be positive and tolerable. However, if it becomes *distress* or toxic, which depends on how much the body and brain are overburdened and how long the events or experiences last, then it becomes more damaging (National Scientific Council on the Developing Child, 2005). The resulting effect also depends on whether the toxic experience is viewed as controllable (which

determines who becomes resilient), and the frequency and duration of the toxic occurrences affecting the system in the past. A victim's vulnerability increases if the trauma is sudden, unpredicted, enduring, or recurring, however, not as much with the intensity of the assault (Campbell, 2012). The potential for developing Post-traumatic Stress Disorder (PTSD) rises if the trauma is complex (Multi-traumatic, for example, as in those who experience domestic violence followed by homelessness), and if the traumatic event occurs in childhood (Sexual abuse early if life has a more profound effect on a child's developing personality) (Schiraldi, 2000).

The brain's response to trauma and abuse (Campbell, 2012).

1. Neurobiological changes can cause unexpected emotions, emotional swings or altered responses (Laughing is not uncommon).
2. Neurobiological changes affect how memory is stored and can make a recall of information difficult or impossible. (Memory fragmentation or *Amnesia*).
3. Tonic Immobility (TI) is real and frightening, as seen in *rape-induced paralysis*; increased breathing, eye closure, and paralysis occur.
4. The rate of 12-50% of victims experiences TI during an assault.

   A case of rape and tonic immobility. At a neighborhood house party, a 20-year-old woman met a guy, flirting, and liked him. He said, "Do you want to go back to one of the bedrooms?" She agrees. They're messing around, sexual activity, not intercourse. She doesn't want to have sexual intercourse. She becomes afraid. She's like "No, no, no. I don't want to do this. I don't know you. I don't want to do this." He doesn't listen. He physically pins her upper body down with his elbow

to hands, not a particularly complicated hold. It terrifies her enough that when her HPA axis kicks in, she freezes and goes into a state of tonic immobility during the assault. She is completely frozen throughout the assault. He finishes sexually assaulting her. He gets up, sees her lying there, he goes out and tells his friends at the party, "Hey, I just had sex with so-and-so and she's still there." So the men line up on the porch to take turns going in and continue to sexually assault her. She was raped repeatedly throughout the course of the evening by men, still laying there in a state of tonic immobility. (Cited by Campbell, R., 2015).

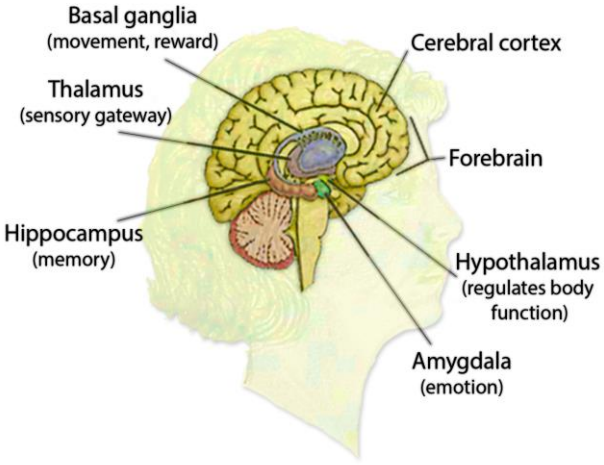

Figure 3. Side view of the brain. Self-created using Photoshop CS6 (2016).

HPA Axis. The Hypothalamic-Pituitary-Adrenal (HPA) axis is a pathway for the release of hormones during trauma (Campbell, 2012). The hormones remain elevated for 96 hours after an assault. The hormones can be released again with retraumatization.

Catecholamines. This hormone produces a fight or flight response for survival. Adrenaline is released.

Cortisol. Energy is produced and made available to support the fight or flight

action.

Opioids. Temporary pain relief occurs, for example, the victim may not immediately feel the pain of an injury during an assault.

Oxytocin. This hormone promotes good feelings. The victim may respond in one of three ways:

- Hyperactivity or hypervigilance, which may last for several days.
- Flat affect or no emotion.
- Laughing or joking when interviewed by Police or Medical personnel.

When the HPA axis hormones are released, it causes memory fragmentation. It can take up to 96 hours before a victim can process her thoughts clearly again or have memory consolidation (Campbell, 2012).

What Trauma-Informed Actions Should I Take as a First Responder?

1. Provide caring and emotional support. Give her a cup of coffee or snack. It helps to shut down her HPA axis.
2. Allow the survivor to sleep one or two cycles. Interviewing the survivor immediately after the assault will make it difficult for her to follow instructions, sign consents, or even to remember the sequence of events that occurred during her assault.
3. Start the questioning with, “Can you help me understand what you can remember about your experience?”
4. Use open-ended sensory questioning, having her remember sights, sounds, touch, or smells, then remain quiet and let her speak.

PowerPoint Slides. TBD.

Epigenetics

The food choices we make, and our past and present exposures to experiences whether negative or positive, influence the health of future generations. Ayurveda, the Indian *science of life*, is an ancient system of healing. The science states that humans possess elements that create health when well-balanced and disease when imbalanced. The purpose of Ayurveda medicine is to help re-balance and restore our systems to health (Himalayan Institute.org, 2014).

When couples are hoping to conceive a happy and healthy child visit an expert in Ayurveda, which is a form of alternative medicine, they are told to follow a surprising set of orders. If either the man or woman feels thirsty, hungry, sad, angry, or afraid, the couple is told to forgo any potential baby-making activity. Only when happy, satiated, and feeling connected to one another should they bathe, dress in fresh white clothing, apply particular oils to their bodies and then proceed. (Ross, 2014, p. 1).

The science known as *Epigenetics* states that the health of our future generations is dependent on all that we consume and experience from conception on to the present (Sadler-Riggleman & Skinner, 2015). Dr. Michael Skinner at Washington State University realized the implications of intergenerational trauma. The research findings suggest that our genes carry memories of trauma experienced by our ancestors and influences how we react to trauma and stress in the present (Brockie et al., 2013; Sadler-Riggleman & Skinner, 2015). Epigenetic changes are an individual's molecular response to the environment and occur to protect and preserve the health of the individual. The

adverse childhood experience most linked to the vulnerability for health-related issues is childhood sexual abuse (Edwards, et al., 2012).

According to Williams et al., (2010), sociologists have posited that social exposures based on racial differences combined with biological influence determine the distribution of disease. For example, the evidence reveals that African Americans, Hispanics, and American Indians have higher age-specific death rates related to chronic conditions such as diabetes, hypertension, liver cirrhosis, and homicide, than Caucasians from birth through retirement (Williams et al., 2010). Also, Black women and Hispanics living in poverty level socioeconomic status were more likely to test positive for elevated levels of stress hormones and conditions that those hormones can set in motion (Williams et al., 2010).

PowerPoint Slides. TBD.

MODULE 2: Cultural Competence

Learning Objectives

- Define the key terms of cultural competence, cultural diversity, racism, and ethnoviolence.
- Examine the prevalence of violence on diverse cultural groups.
- Assess your personal biases of different cultural groups within your practice and society.
- Evaluate the importance of becoming culturally competent in healthcare and social services.
- Distinguish the five components of becoming culturally sensitive according to Campinha-Bacote.
- Discuss the different ways to meeting the needs of diverse cultural groups.
- Learn how to perform a Culturalogical assessment.

Sojourner

A traveler that dwells for a time; to dwell or live in a place as a temporary resident, or as a stranger, not considering the place as his permanent habitation. Cultural sojourners are temporary visitors to other countries who eventually return to their home country (King James, Gen. 12).

> When a stranger sojourns with you in your land, you shall not do him wrong. You shall treat the stranger who sojourns with you as the native among you, and you shall love him as yourself, for you were strangers in the land of Egypt. (Leviticus 19:33-34 ESV)

What is Cultural Competence?

The definition of cultural competence varies across disciplines and organizations. One definition that addresses cultural competence at the service provider level was stated by Denboba (1993) as follows:

Cultural competence is the ability to evaluate one's value and belief system and achieve the desire to learn and understanding the values, knowledge, skills, and attributes of other groups that support cross-cultural efforts. Organizations, programs, and individuals must have the ability to become culturally competent by (SAMHSA, 2014):

1. Being aware of your worldview and biases toward cultural differences.
2. Learning to appreciate diversity and similarities among cultural groups.
3. Reacting positively and supporting cultural differences.
4. Reframing the delivery of services and engaging the appropriate support to promote healing and resilience within diverse groups.
5. Working towards developing and implementing a culturally sensitive plan for sustainability.

Question to the Audience. What do you think is the importance of understanding cultural diversity in domestic violence organizations?

Culture and its Effect on the Response to Violence

Demographics. The National Intimate Partner and Sexual Violence Survey (NISVS, 2010) prevalence of intimate partner violence on women by race and ethnicity reported that the following diverse groups were affected:

- American Indian/Alaska Native - 51.7%

- African American - 41.2%
- Caucasian - 30.5%
- Hispanic - 29.7%
- Asian or Pacific Islander - 15.3%

The NISVS (2010) and Office for Victims of Crime (OVC, 2014) reported lifetime sexual violence against those in the Gender and Sexual Minority group (GSM, previously LGBTQ) shown as follows:

For women.

- Lesbian – 46.4%.
- Bisexual – 74.9%.
- Transgender – 66%.

For men.

- Gay – 40.2%.
- Bisexual – 47.4%

Table 1

U.S. Census Bureau: 2009 National Population Projections (Census.gov).

U.S. Population Projections by Race and Ethnicity				
	2020	**2030**	**2040**	**2050**
White, not Hispanic	60.1%	55.5%	50.8%	46.3%
Hispanic (of any race)	19.4%	23%	26.7%	30.2%
Black, not Hispanic	13%	13%	13%	13%
Asian	5.5%	6.3%	7.1%	7.8%
American Indian/Alaskan Native	1.1%	1.2%	1.2%	1.2%
Native Hawaiian/Pacific Islander	0.2%	0.2%	0.3%	0.3%

The U.S. projection regarding population growth for the next 34 years.

Considering the complexities of each person's identity as a possible factor in response to trauma helps support strategies to promote resilience (cited by Rodriguez, 2016). The individual's worldview, social structure factors, ethnohistory, language and professional care are critical components that predict health, wellbeing, illness, healing and the victim's perspectives of disability and death (cited by Rodriguez, 2016; see *Figure* 5). Engaging culture in cases of violence helps to shape a victim's experience and a perpetrator's response to intervention.

Warrier (2016; cited by Rodriguez, 2016) stated the following:

- People do not have one identity in trauma.
- All cultures include values that are oppressive as well as those that are protective of individuals.
- Each comes into any encounter with cultural experiences and perspectives that might differ from those in that particular system.

SAMHSA (2014) adds that cultural factors can affect:

- How one decides whether to seek treatment within their cultural group or outside in the mainstream culture.
- The response to treatment.
- The treatment outcome.

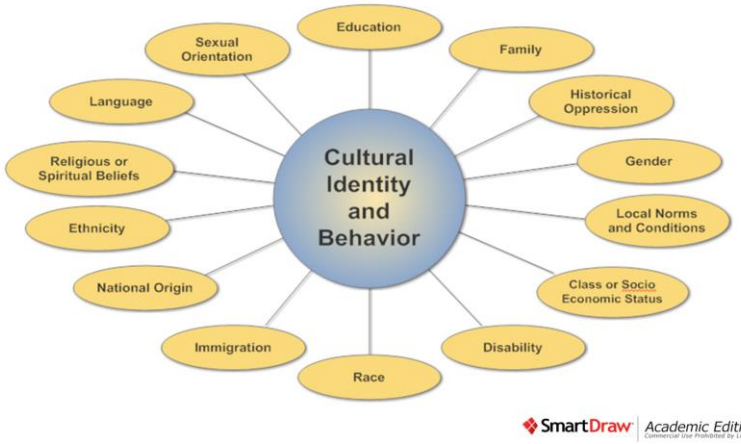

Figure5. The influences on cultural identity and behavior. *Alianza*, A cultural competency training for domestic violence service providers and advocates.

It is the responsibility of the service provider to advocate *personal sovereignty*, in other words, supporting the right to your mind and body. Cultural rights can rationalize activities that discriminate against women and other marginalized groups in a community (cited by Rodriguez, 2016). In domestic and sexual violence, culture can justify the continuing abuse and oppression of women. Feministic views posit that minority cultures are more sexist than Western culture and thus the women are more at risk for abuse.

Racism. Racial and cultural discrimination are structured on the principles of group ranking and devaluation as being inferior. Negative attitudes (prejudice), beliefs (stereotypes), and differential treatment (discrimination) toward diverse racial and

cultural groups, by both individuals and organizations, is a consequence of racism (Williams & Mohammed, 2013). Cultural racism is associated with negative cultural stereotypes and the lack of positive support for those affected influences the course of policymaking to address inequalities in health (Williams & Mohammed, 2013). As a result of the dominant society's beliefs, the stigmatized groups respond by accepting these biological and/or cultural inferiority stereotypes as true, which in turn, adversely affects their psychological well-being; the sequelae of which may include alcohol consumption, psychological distress, obesity, and elevated blood pressure (Williams & Mohammed, 2009) and decreasing motivation for socioeconomic attainment (Kwate & Meyer, 2011).

Ethnoviolence. *Ethnoviolence* is one structural factor directed at diverse ethnic groups. The exposure to race-related trauma may be the primary cause in the development of post-traumatic stress disorder (cited by Rodriguez, 2016). In the case of an ethno-violent rape of a Native American woman, although the psychological and emotional abuse may occur together; the physical assault is viewed as the primary source of the trauma. If the service provider perceives the person of color as arrogant, opportunistic, or hypersensitive, the effect of the original assault is minimized. The provider might not view the traumatic episode as racist or as a violation of the individual's personal being, and the victim is potentially revictimized (cited by Rodriguez, 2016).

Becoming Culturally Competent

Culturally competent individuals value and adapt to diversity, understand each survivor in the context of life experiences and cultural background and adapt to the cultural contexts of the communities they serve. Cultural competency is viewed by Campinha-Bacote (2002, 2009; cited by Rodriguez, 2016) as an ongoing process in which the health or social service provider continuously strives to achieve and maintain culturally sensitive interactions for the client, their family, and community. It is a process of *becoming* culturally competent over time rather than achieving competence as a final objective of this seminar. The five components of the framework are cultural awareness, cultural desire, cultural knowledge, cultural skill and cultural encounter.

PowerPoint. TBD.

Video. Why Cultural Diversity Matters, Michael Gavin, TEDxCSU, Playtime 17: 52. Retrieved from https://www.youtube.com/watch?v=48RoRi0ddRU&list=PLU5O9-ea6xDkU0cIxTa9y1GbqKRgS1DeN&index=1.

Biography. Michael Gavin, the associate professor of human dimensions of natural resources, researches biological diversity and discusses the importance that history, language, and tradition have in the preservation of culture.

The Framework of Cultural Competence

Cultural awareness. Cultural awareness is the first important step in working well with diverse cultural groups. The process begins with a personal journey of examining one's cultural perspective. It allows the individual to acknowledge the biases and prejudices towards those who are different from one's culture. When individuals

recognize the differences that another culture possesses and compares it to their own deeply held cultural expectations, this collision creates a state of *ethnocentrism* or perceiving their culture as normal and outsiders as different or deviating (NCCC, 2015). It is common in every culture to view one's cultural group as more important than other groups. The levels of cultural awareness are as follows (Quappe & Cantatore, 2005):

1. ***My way is the only way***. People believe that their way is the best way. They ignore the impact of cultural differences.
2. ***I am aware of their way, but mine is still better*.** People are aware of other ways of doing things, but they still believe their way is better. Cultural difference is viewed as problematic. Thus the other cultural groups are ignored or considered insignificant.
3. ***My way and their way***. Individuals are aware of their way of doing things and others' way of doing things. They start to recognize that cultural differences can lead to both benefits and problems and they are willing to use cultural diversity to create new solutions and alternatives.
4. ***Our way***. Those from different cultural backgrounds come together to create a culture of shared meaning. They have regular discourses with one another and develop new rules to address a particular situation.

PowerPoint slides. TBD.

Recommended websites.

1. Harvard University's Project Implicit (Biases evaluation), retrieved from https://implicit.harvard.edu/implicit/takeatest.html.
2. Understanding Prejudice, retrieved from http://www.understandingprejudice.org/.

Activity. Participant focus group exercise:

1. What biases do you have about people of other cultures?
    a. What misunderstandings have arisen because of your biases?
    b. What steps should you take to prevent these misunderstandings from affecting your work with your co-workers and clients?

Cultural desire. According to Campinha-Bacote (2003), cultural desire involves the motivation of the staff to "want to" rather than to "have to" participate in the process of becoming culturally proficient. Cultural desire encompasses the concepts of empathy and caring. This process includes a genuine compassion and commitment to be receptive to the differences and welcomes the knowledge from others as *cultural informants*. It is referred to as a lifelong learning process called *cultural humility* (Campinha-Bacote, 2002). Humility is not thinking less of yourself, but thinking of yourself, less (Strozier & Warren, 2004, p. 38). The process encompasses a commitment to self-evaluation, addressing the power imbalances in different cultures in comparison to the mainstream culture while forming symbiotic relationships.

There is no greater agony than bearing an untold story inside you. (Maya Angelou, n.d.).

Compassion is a shared feeling that arises when you are confronted with the suffering of another individual, generating a desire to relieve that suffering (Greatergood.berkeley.edu, 2016) by creating a space where the survivor is in the company of believers who will listen (Nouwen 1998). Compassion is difficult because it involves entering into the pain of another and understanding how your actions are affecting the other person (Gallaher, 2007). Such an interaction is referred to as a *sacred encounter* or the meeting of a profound need that the person possesses with a loving response (Chapman 2005). Every cultural meeting is a considered a sacred encounter (Campinha-Bacote, 2011).

The difficult question is, "How do we convince ourselves and others to want to be culturally sensitive?" One answer is to interact with culturally competent coworkers or colleagues, leadership, or listen to speakers at conferences or conventions who are passionate about the concept. When a person stops to listen, experience and understand the plight of others, it creates an empathetic response and innate desire to be committed and flexible with the differences of those diverse cultural groups. These diverse individuals are viewed as cultural experts (Campinha-Bacote 2003). Cultural desire involves a genuine passion and commitment to caring and loving. We are all unique individuals who not only belong to the human race but who also should coexist as part of the *humane race*.

Campinha-Bacote (2002, p.182-183) quoted that "people do not care how much you know until they first know how much you care." It is a type of caring that comes straight from the heart and not just by verbalizing it. Individuals who are devoted to

serving others over themselves are thought of as having a ‘Servant’s Heart’ (Chapman, 2005) for it symbolizes love’s greatest expression of sacrifice. The sacrifice of one’s prejudice and biases towards those survivors who are culturally different is required to achieve cultural desire.

Finally, cultural competence is grounded on a pledge to social justice. It is necessary for the DV workforce to possess the skills to make a change from practices that perpetuate health and social inequities because of cultural differences (Stacks, Salgado, and Holmes, 2004).

Video recommendation. *The Power of the Heart,* a one hour and twenty-four-minute documentary, retrieved from http://www.thepoweroftheheart.com/en.

PowerPoint slides. TBD.

Cultural knowledge. Cultural knowledge is the process of pursuing and retaining accurate information about diverse cultures. Culture is the specific pattern of behavior that gives meaning to the human expressions of care. As per McFarland & Wehbe-Alamah (2014; cited by Rodriguez, 2016), caring is essential to curing and healing, for there can be no curing without caring. Every human culture has lay (generic, folk, or indigenous) care knowledge and practices, which vary transculturally.

Culturally specific service providers are aware that even if you address the presenting problem of violence, there is still pain and trauma that survivors face in their daily life. Service providers are not only supporting survivors, their families, and communities from dealing with the sequelae of violence but they are also aiding in the prevention and the recurrence of violence. It is of utmost importance that we

continuously hold ourselves accountable by releasing inappropriate assumptions about different cultures, sexual orientation, and gender identity (LaGrone et al., 2011). Survivors who are cared for by DV staff that are in conflict with their beliefs, values, and caring lifeways will start to manifest signs of cultural discord, noncompliance, stress and ethical or moral concern (Leininger, 2009) which in turn, may cause them to stop seeking services altogether.

To seek cultural knowledge, the DV staff should bear in mind two points:

- All cultures have some form of health-related beliefs and values. Service providers need to understand their client's worldview since it guides how their clients translate their social situation and form their thinking processes and behavior.
- It is of utmost importance to collect accurate data on diverse cultural groups since domestic, and sexual violence varies among these groups. The collection of demographic data helps to guide decisions about treatment, education, screening, and prevention programs that will promote positive outcomes.

Question. Whom do you serve? What is the demographics of your populations?

PowerPoint slides. TBD.

Cultural skill. Cultural skill is the ability to collect important information on the survivor's presenting health and social concern that may potentially be a consequence of her or his culture. It involves learning how to perform a cultural assessment. Campinha-Bacote, J. (2011) states that is important to understand that regardless of your client's acculturation status to the mainstream culture of the U.S, they are still members of

specific cultural groups from which they came, which may influence their health and social beliefs. There are two important facts to remember (Narayan, 2003):

- Cultural assessments should not only be limited to specific ethnic or cultural groups but also performed with the understanding that survivors possess characteristics from within their kinship, across their cultural group and may also incorporate lifetime experiences especially if they have acculturated to the mainstream society.
- Using cultural guides is just a small part of becoming culturally competent. The only way to obtain a true perspective of another culture is by directly asking the client (Narayan, 2003).

According to McFarland et al. (2012), there are two principles that can be used in caring for domestic and sexual survivors from diverse cultural groups:

- Maintain a receptive viewpoint about each survivor.
- Avoid seeing all survivors of diverse cultural groups as similar. They are not.

Adhering to these principles will allow care providers to learn how others view health and illness and help to support the formation of therapeutic relationships.

Cultural assessment. A cultural assessment is a systematic evaluation of culturally diverse groups, and communities by examining their beliefs, values, and practices. The assessment helps to unfold the specific needs of the population that directs the planning of intervention strategies within the context of the diverse cultures (Campinha-Bacote, 2011). Performing a cultural assessment of a survivor after violence,

helps the provider to recognize certain indigenous physical, psychological, and social characteristics that may either support or hinder the care given.

Leininger (2002) recommends conducting a *Culturalogical* assessment that is holistic and encompasses the worldview and social structure of the survivor. According to Leininger (2002), the goal of a *culturalogical assessment* is:

1. To discover the clients' beliefs, values, and practices through the examination of their sociological patterns and meanings.
2. To obtain cultural knowledge enlisting the help of the clients as cultural informants to make decisions and initiate care planning.
3. To understand the specific cultural patterns that guide decisions to accommodate the clients' beliefs, values, and practices.
4. To realize the professional knowledge that can be beneficial and discussed with the client.
5. Finally, to determine the potential conflicts and areas of cultural neglect that may result from misunderstandings between the clients and the DV staff.

Cultural assessment can be challenging. Some authors have developed mnemonics to initiate the evaluation. Berlin & Fowkes (1982) recommended using the mnemonic, LEARN, to perform a cultural assessment. This five-step mnemonic is shown as follows:

- L isten
- E xplain
- A cknowledge

- R ecommend
- N egotiate

Using this mnemonic model, the DV staff member can begin by *listening* to the survivor's story of the incident and having the survivor *explain* his or her viewpoint of the problem (See example questions in the full Culturalogical assessment under Addendum C). The staff member *acknowledges* that the incident was an unfortunate action targeted towards the survivor and inquiries from the survivor what was most concerning about the incident. Next, the staff member determines whether the client has sought assistance from alternative socio-health services, family, acquaintances, or other individuals who are not professionals. The staff member collaborates with the survivor to *explore*, *recommend*, and *negotiate* options in developing an intervention that will be mutually acceptable to both the staff and client. Engaging the input of the survivor, family, and all other resources is imperative during all components of the assessment process. The results of the assessment provide knowledge for the formation of an individualized care plan that considers both the survivor's culture and lifestyle. The joint effort helps to promote a trustworthy relationship for positive outcomes.

Culturagram. The culturagram is a helpful adjunct tool in step towards effective care planning for families of diverse cultures. Upon completion of the culturalogical assessment, the significant data is entered into a culturagram. In doing so, the necessary information will be emphasized and prioritized for effective translation into practice (see Figure 8).

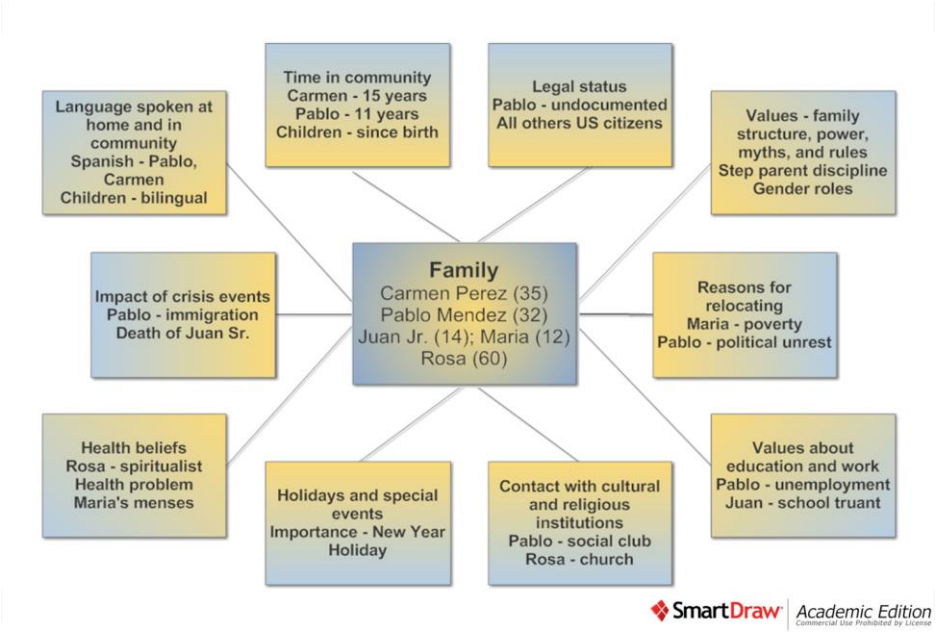

Figure 8. A completed culturagram.

The culturalogical questions are written in a way to ensure a sense of being heard and understood which in turn, helps to promote a trustworthy discourse with the care provider. The client is an important contributor to the development of a cultural care plan. Presenting inquiry to the client that is dynamic and conversational rather than direct is a more productive approach. If the questions are asked by initially presenting a *declaratory statement*, the client may feel less threatened and more likely to reveal his or her cultural perspective without fearing the possibility of stigma from the staff (Leininger, 2002). Narayan (2003) presented examples of declaratory statements:

1. At times like this, many people draw upon their religious or spiritual beliefs to help them.
    a. Can the DV staff help you in any way to provide you with quiet time or space to help you seek spiritual strength?

   b. Are there certain spiritual services that we can mobilize for you during your stay with us?
   c. How can we help you find a religious leader or healer to support you?

2. The staff wants to be polite and respectful to you and your family.
   a. What is the most appropriate way to address you?
   b. Could you please let us know if anything we do seems rude or offensive so we can improve your experience during your stay with us?

3. Everyone has cultural beliefs and customs that they find help them to heal.
   a. Are there special beliefs, customs, herbs, foods, or treatments you would need to help you heal?
   b. Does your family have other ideas on how to manage this problem?
   c. How do you feel about the care plan we developed for you?

PowerPoint slides. TBD.

Handouts.

Addendum B. Cultural Competency Communication Assessment

Addendum C. Culturalogical Assessment

Addendum C. Cultural Care Plan

Activity. See Addendum D. Develop a Culturagram.

Cultural encounter. Cultural interaction involves the process of direct staff engagement with clients from culturally diverse backgrounds. The cross-cultural encounters help to refine one's perspective when providing care; for example, it will allow the service provider to assess the client's linguistic needs to gain knowledge for

effective communication. The assumptions of the model state that (Campinha-Bacote, 2002):

- Cultural competence is an ongoing process, not a one-time event.
- There is more diversity within ethnic groups than across ethnic groups (intra-ethnic variation).

Survivors of diverse cultural groups tend to have very different experiences from each another and their service providers. Acquiring knowledge through cultural encounters would offer an opportunity for the service providers to receive direct, on the field learning about their clients' cultural background. In this way, they can modify any existing beliefs or stereotypes they have about the groups they serve (Campinha-Bacote, 2002). These encounters are essential but may still require ongoing interactions with varied individuals of the same culture for a true perspective of the cultural practices of the group.

To develop culturally specific services within domestic violence organizations, it is important to have cultural leaders and organizations from communities develop and direct services, to have staff listen to advocates from these communities, and to remember that the experiences of trauma are diverse (Phillips et al., 2015). Incorporating these practices will increase the understanding and appreciation by the DV staff regarding various aspects of the cultures that hold important meaning for the survivors they work with. One option is to introduce *Service Learning* to the workforce of DV organizations.

Service learning is an organized learning experience that involves staff participation in community service that contributes to their development as culturally

competent providers (Meyer et al., 2006). The DV trainees would participate in collaborative groups to serve a community in need using the community as an "educator." The experience offers knowledge regarding the milieu in which the service is provided, and the connection with domestic violence. Service learning is a fundamental way to improve the cultural competency of the DV staff and helps to strengthen community and organizational partnerships (Meyer, D. et al., 2006). The following are examples of integrative cultural learning objectives achieved through the service learning experience (JointCommission.org, 2016):

- It is essential to examine one's biases and prejudices before engaging in the process. Promote a cultural self-awareness discussion with the trainees of the DV organization.
- Identify similarities and differences in the main characteristics of the survivors and families of particular diverse groups.
- Construct plans for the cultural care of clients and families from diverse cultures and across the life span.
- Conduct community assessments in diverse communities.
- Evaluate sources of knowledge and information.
- Plan community projects involving members of the community to tell their cultural stories, for example, at health fairs, community forums, or meetings. It will educate the community regarding any concerns they may have on specific cultural values, beliefs, and practices.

- Collaborate in role-play scenarios of stereotyping, racism, discrimination, etc. in health or social service care settings.
- Attend seminars or conferences by authorities within the community for cultural awareness.
- Partake in cultural immersion experiences.
- Learn about the foundation of specific cultures by participating in their cultural or religious events.
- Assess organizational and community resources appropriate for client needs.
- It is important to learn how to work with translators and interpreters in actual client care situations for survivors of limited English proficiency (LEP).
- Promote cultural sensitivity by reviewing and translating handouts, brochures, documents, and multimedia.
- Meet with community folk practitioners from various cultures. Go shopping and dine at cultural stores and restaurants.
- Support quality improvement projects specific to diverse cultural groups.

PowerPoint slides. TBD.

Acculturation. Another component of cultural competence is understanding the degree to which individuals have *acculturated* **(**adopted the traits of the new mainstream culture in which they reside) (cited by Rodriguez, 2016). Acculturation is a sociocultural process that occurs in multi-dimensional stages. The stages of adjustment are *cultural assimilation* and *social assimilation* in which, the individual will first try to understand the values, customs, and language of the new society followed by the social integration through their involvement in social gatherings, clubs, or institutions (cited by Rodriguez, 2016). It is important to consider how diverse ethnic groups may assimilate differently based on their unique environmental experiences, cultural orientation or existing political turmoil occurring in their country and the impact it has on acculturation and health outcomes (cited by Rodriguez, 2016).

Culturally competent care is a moral good, ethical and emerges from a commitment to ensure survivor sense of control, autonomy, and justice. One area of concern is the need to remove barriers to medical and social care for those cultures that are especially susceptible to health disparities. In considering the ethical approach, there are three essential principles to abide by (Barnett & Johnson, 2015):

- Principle 1. Acknowledge the important role that culture plays in people's lives.
- Principle 2. Respect the diversity of culture.
- Principle 3. Avoid care practices that induce any negative consequences on cultures.

MODULE 3: Resilience

Learning Objectives

- Define resilience.
- Review the domains of resilience.
- Distinguish between adult and child resilience.
- Learn how to foster resilience in both groups.
- Recognize vicarious traumatization and identify ways to foster resilience within yourself.

What is Resilience?

Leppin et al. (2014; cited by Rodriguez, 2016) views resilience as the "ability of individuals to absorb life's challenges and to carry on and persevere in the face of adversity." Resilience (Latin version *resilire*, or to rebound) is diverse in itself. An individual may manifest varying degrees of resilience across a lifespan, for example, in one aspect of a survivor's life (For example, Adolescence) but not in another (Intimate relationships) (McCraty, 2015; Southwick et al., 2015). Buhle et al. (2014) state that resilience has been linked to the ability to use strategies in regulating emotion, accepting the things that are out of one's control and always being mindful of the events at the present moment.

Another important issue is how resilience is viewed across different cultures. When planning culturally sensitive, trauma-informed assessment and intervention for families, it is vital to appreciate their cultural beliefs within the context of trauma. In various cultures, parenting may involve the participation of not only a mother and father

but also an extended family, which includes aunties, grandparents, siblings, or even closed knit friends that partake in the upbringing of the child (Bowie et al., 2013). Working with families to determine what their culture dictates around the expression and support of strong emotions such as trauma-induced anxiety or depression, is important if strategies to regulate these emotional states are to be successful (Bowie et al., 2013). As the traditional African Proverb goes, reiterated by Presidential candidate Clinton (n.d.), "It takes a village to raise a child."

According to Panter-Brick (2014; cited by Rodriguez, 2016), analyzing the social determinants of health, for example, viewing how racism will structure unfair access to health care and how poverty dictates poor health outcomes is fundamental to the development of resilience. The central goal is to use research to obtain critical knowledge for effective interventions that maximize life chances and identifies resources that really matter at any given point in human development (cited by Rodriguez, 2016).

McCraty (2015) discusses resilience as a state rather than a trait, and a survivor's resilience can transform over time as needs, situations, and degree of maturity changes. The ability to develop resilience is based on four areas, namely physical, emotional, mental and spiritual shown as follows:

- *Physical resilience* is manifested in physiologic flexibility, endurance, and strength.
- The ability to control the flexibility of one's emotions, having a positive attitude and supportive relationships is referred to as *emotional resilience*.

- *Mental resilience* entails the capability to maintain focus and attention, mental flexibility and aptitude in assimilating various viewpoints.
- *Spiritual resilience* is associated with the loyalty to core values, intuition and the acceptance of others' values and beliefs.

When cultivating resilience, survivors need the physical strength and its connection to the mental and emotional elements to develop the energy that fuels all four areas. Resilience is important not only for bouncing back from challenging situations like trauma, but also for avoiding unnecessary stress reactions such as frustration, impatience, and anxiety (McCraty, 2015). The ability to control one's emotions and attitudes is essential and at the core of many personal and social problems today. Trauma may be the contributing factor that alters the maturing process or ability to attain certain skills to self-regulate. The ability to self-regulate enables people to mature, meet the challenges and stresses of everyday life and make wise decisions with resilience (McCraty, 2015).

Fostering Resilience

Supporting individual strengths is a necessary component in promoting resilience and preventing revictimization. Restoring connections to family, culture, community, and spiritual systems are central to the survivor, and may divert the negative effects of trauma upon subsequent generations (SAMHSA, 2014). The training of *resiliency coaches* among the DV workforce would provide an effective option for building resiliency within the organization since the process is similar to 'becoming culturally competent;' it is an ongoing development of exploration, learning, and practice. The journey should begin with the training of experienced DV staff, representing the best fit for the resilience coach

role. To educate inexperienced staff on how to be resilient would be challenging as oppose to seasoned individuals who possess foundational knowledge from the onset.

Strengths-based approach. It is important to emphasize the survivor's internal and external strengths during a change process. An individual's strengths should be brought to light and validated when challenges are recognized (McCaskey, 2008). Using strengths-based questions offers a sound initial approach to discussing traumatic experiences with survivors, some examples are shown as follows (SAMHSA, 2014):

- It seems like you have accomplished a lot since the trauma. Which ones are you most proud of?
- What do you feel are your strengths now?
- Are you able to manage your current stress?
- How do you deal with painful feelings?
- If you were in a situation of needing physical, mental or emotional support, who would be there for you?
- What does recovery look like for you?

Adults

According to Southwick et al. (2015), resilience emerges from inner personality strengths, the connections to community resources, and one's own acquired coping skills. The framework of the Individual Resiliency model consists of five core factors representing stops along the way to resilience. The framework is relevant to adults, children, and victim service providers, examples of each factor are delineated as follows (OVC.gov, 2016):

1. **A sense of hope**. It is the understanding that regardless of the negative challenges life may bring you, it is important that you maintain a positive viewpoint or a belief that things will be better in the future. A positive perspective is supported by being optimistic, include humor in your life, and make time to have fun. Some examples include (OVC.gov, 2016):
    a. ***Develop opportunities to succeed.*** Seek opportunities that offer you achievable goals and fulfillment in life.
    b. ***Practice gratitude***. Appreciating all that is good or going well in your life helps to balance negativity even if it means just enjoying the company of your favorite people.
    c. ***Give praise***. Identify and appreciate yourself and love ones, such as parents, siblings, close friends, or your children. For many individuals, your loved one's help ground you and help maintain a framework of values for healthy living.
    d. ***Find appropriate ways to have fun.*** Having fun helps to minimize tension and stress. Attaining resiliency can be challenging if you are unable to surrender to having fun. Note all of the things you would love to do in life to make you happy and take your time in reaching every goal. There are no time limits for happiness.
2. **Healthy coping.** Healthy coping means moving forward and balancing the negativity of your life with positive influences. It involves caring for yourself in a holistic way.

a. ***Learn to identify your physical stress reactions***. It is important to recognize your own stress-related emotional, mental and physical symptoms, then collaborate, participate, take risks, and be creative for building resilience to produce positive outcomes.

b. ***Balance your life***. It is important that you reach equilibrium in your life's routines with activities that separate you from trauma (even if for only a moment) and reaffirm the goodness of life to restore energy (See 2d). Emotional, mental, and physical protective behaviors (For example, rest, nutrition, and exercise) contribute greatly to overall well-being.

c. ***Get adequate sleep***. The lack of sleep may affect your personal reserves and place you at risk for poor coping ability. The National Sleep Foundation (2015) recommended the appropriate time frames considered adequate sleep in adults and children. The ability to sleep well is an important component of becoming resilient but something we take for granted.

d. It is best to create a sleeping environment, starting with a cool room (about 68 °F), your favorite mattress and pillow, low or no lights, and no electronics. Play soft, calming music to promote sleep; consider using guided relaxation and imagery instruction (See 2d).

e. ***Develop calming and modulation techniques.*** When we do deep breathing and relaxation techniques, it helps us to calm the tension within and restore our spirit. *Mindful Awareness and Breathing* is one such method in which we maintain a moment-by-moment awareness of our thoughts, feelings, bodily

sensations, and surrounding environment (GreaterGood.Berkeley.edu, 2016). Mindfulness is a type of secular practice in Buddhist meditation that has entered into mainstream America in recent years. Mindfulness allows us to accept our thoughts and feelings at face value without passing judgment on them at any given time, rather than to re-experience the past or envisioning the future (GreaterGood.Berkeley.edu, 2016). Mindfulness promotes positive feelings, helps us to understand the suffering of ourselves, others and guides us in regulating our emotions while reducing stress. As Einstein (n.d.) quoted, "The intuitive mind is a sacred gift, the rational mind a faithful servant, we have created a society that honors the servant but has forgotten the gift."

f. ***Change the pace***. Changing your routine may help you regain perspective and rekindle creativity. You may consider engaging in a new hobby or an expressive activity such as art therapy, movement therapy, or storytelling.

3. **Strong relationships.** Relationships are bound by connections to others, seeking and giving support, and speaking up for a change. Forming positive bonds with significant individuals in your life is important to emerge resiliently. Also, developing new relationships are just as important. We all need some form of help during our lifetime and need to recognize and reach out to others even if they do not request it.

   a. ***Enhance communication skills.*** Open and honest communication strengthens relationships. Conveying your emotions and needs clearly, and having the ability to impart and share your feelings with others and in situations is

crucial.

b. ***Collaborate.*** When people join, they gain the energy of their relationship, and community resources to problem solve more effectively. Service provider /survivor relationships benefit from collaborative efforts in providing and receiving services such as self-help groups, medical services, and social service programs. It is always important to be part of your healing and recovery.

c. ***Seek inclusivity and diversity.*** When we respect diversity and be inclusive in our practice, it increases our capability for coexisting well with others. Some survivors feel more comfortable if cared for by providers of similar race and culture, which helps to reduce stress and enhance resilience.

d. ***Strive to be genuine, empathetic, and warm***. Being genuine, empathetic, and warm represents the characteristics of a resilient service provider who supports the foundation for building trustful, therapeutic relationships.

4. **Self-knowledge and insight.** Self-knowledge and insight refer to knowing who you are, having a clear sense of what you believe in, and being aware of what you feel inside instead of accepting what others want you to be. This concept includes identifying your strengths and weaknesses.

   a. ***Identify themes associated with discomfort***. It is important to recognize and address personal triggers that lead to distress. You or your client may realize that specific cultural groups or types of victimizations are more challenging to manage because of lingering past life experiences. Knowing the level of the

survivor's discomfort prepares you for their potential reactions to avoid retraumatization. Reflecting and planning with your client to manage situations in dealing with these discomforts are effective resilience strategies.

b. ***Individualize services to each victim.*** You will enhance your clients' resilience if you take the time to consider their needs on an individual basis rather than always following a conventional approach. Ensure that you are treating every survivor with belief, empathy, and compassion.

5. **Personal perspective and meaning.** Morality, integrity, spirituality, and coherent life meaning support personal perspective and meaning.
    a. Integrity is the foundation of morality.
    b. Integrity is about stability and is an ethical concept.
    c. Spirituality is a bond with the divine being and helps form our values. Resiliency emerges from spirituality through the attainment of inner peace.
    d. Life meaning is an individual's personal understanding of purpose and meaning of life and the world in general.

Children

Many children exposed to violence end up living each day in a perpetual state of survival (repeatedly reacting in the flight or fight response, even in the absence of danger) which may adversely affect their development. Many of these children continue to suffer from the sequelae of trauma, even after the violence has ended (Listenbee & Torre, 2012). Providing the children with a supportive, protective and stable environment, helps the children to overcome adversity and achieve resilience (Cicchetti,

2013). Nevertheless, the question remains, why do some children do so well with adversity and others suffer such negative outcomes?

Rusch et al. (2015) examined women exposed to assaultive trauma in association with the ability to develop psychological resilience. The study revealed two important factors that influenced a survivor's ability to become resilient, *Mastery* (The ability to have control over life's difficulties), and *social support*. Strong and loving role models, healthy peer relationships, effective schools, and supportive communities are components of a supportive environment that help to promote motivation, mastery, and self-regulation capabilities (Masten, 2014). Mastery and the presence of social support are far better predictors of resilience for those exposed to violence. Many studies qualify resilience as being highly dependent on the individual, their family, available resources, as well as community setting and cultural characteristics, all within the context of society and government at large (Hornby Zeller Associates, 2014). An individual's resilience can change over time, and manifest in various ways at different stages of development or across one's lifespan. To date, researchers have consistently found that the most important factor necessary for building resilience and minimizing the effects of toxic stress for children is the presence of a consistent, caring adult (Hornby Zeller Associates, 2014).

Children of different ages vary in their response to domestic and sexual violence. Knowing their developmental stage places the trauma in context (Pearson & Hall, 2006). The DV workforce and parents can support children by providing a physical, mental, and emotional structure and routine. The best opportunity that a child can have for healing

from trauma is the presence of a warm and loving caretaker who can recognize and acknowledge their children's feelings (Hornby Zeller Associates, 2014).

Fostering Resilience in Children

Fostering resilience in children involves supporting their inner strengths, some of which include confidence, emotional regulation, cognitive skills, and the ability to maintain an optimistic viewpoint. Outside supports are also of great significance in retaining buoyancy in life whether it is through loving relationships or strong role models in families and communities (*reachinginreachingout.com*, 2016). The more service providers understand the response of youths and parents to trauma, the quicker improvement of care practices can be to support families towards resiliency.

The Reaching In, Reaching Out (RiRO) organization. The organization, *Reaching in, Reaching out*, describe its title as the ability to "reach within" or to think more flexibly and accurately. On the contrary, "reaching out" is to enlist the help of others, and engage in positive opportunities (ReachinginReachingout.com, 2016). It represents what Masten (2009) calls "Ordinary Magic." The RiRO program was developed to help adults and young children form resiliency skills. The idea evolved from over 30 years of research. The program educates parents to perform the skills needed to handle the challenges life presents with resilience and then pass those skills on to the children. The organization developed two programs, the *RIRO Resiliency Skills* Training (12-hour) for service providers and *Bounce Back & Thrive!* the 10-session activity based version for parents, focusing on enhancing relationships to support self-regulation (emotion and behavior), problem-solving, mastery motivation and meaning making

(optimism, participation, hope). Outcome evaluations were performed regarding the efficacy of these programs. The results (Hall, 2014) showed that, both the adults and children experienced more positive relationships, greater calmness, and less stress, increased confidence and perseverance, greater ability to "re-think" challenging situations before responding and a more positive and hopeful outlook. Based on nearly 1,800 participants that were involved in their impact evaluation, the results provided strong support for the efficacy of RIRO's skills training programs in building the capacity for resilience and supporting the well-being of service providers, parents, and young children. The skills training content is consistent with the framework of world-renown resilience researcher, Masten (2009, 2014), and the work of other leading investigators in the fields of resilience, positive psychology and brain development.

What can adults do to help children develop key resiliency factors (**Hall, 2014)?**

- Self-control during stressful situations and delayed gratification are important components of emotional regulation when educating children.
- Teaching awareness and problem identification are excellent skills for children to develop to promote positive outcomes.
- It is crucial for children to learn how to identify the cause and effect of their emotions at any given time, and not be fearful of asking for support or guidance.
- Parents, guardian and other role models are important facilitators for developing self-worth in children. The responsibility of parents and guardians is to support

children in possessing an interest in life, and encouraging them to actively engage with others and important opportunities.

- According to Masten (2009), cultural values, beliefs, and practices play and important role in achieving resilience, although protective factors rooted in culture have been ignored or viewed as insignificant in research.

Parents, teachers or other caregivers who act as positive role models in the resilient way of thinking will nurture children's lifelong capacity for resilience and effective coping strategies in response to traumatic stress (RiRO.com, 2016). The National Child Traumatic Stress Network (2010) have provided a list of children's reactions to trauma based on the stage of development shown as follows,

Ages (0-3). When babies experience trauma, they express their symptoms as a physical manifestation. Physiological responses to trauma include:

- Babies are not easily pacified.
- Dysfunctional sleeping and eating patterns.
- Adverse changes in bowel function (Increased flatulence).

Support the Parents in:

1. Maintaining a close presence to their children helps to ensure consistency in their care routines.
2. Offer the children choices that allow them to make decisions for their environment, for example, choosing playtime activities, deciding on preferred food items, or adhering to sleep options.
3. Provide reassurance when the child needs it. You cannot spoil your baby by

picking him or her up when they cry. Young babies do not have the capacity to understand the concept of being spoiled. Being held and cuddled helps your baby learn to soothe him/herself and feel more secure. This will help him/her learn to do things on their own when they are older.

4. Name the child's feelings.
5. Repetition is needed in young children for reassurance.

Ages (4-5). Physiological responses to trauma include:

- Young children are unable to pacify themselves.
- Children demonstrating difficulty or demonstrating an adverse change in eating and sleeping patterns.
- Children are experiencing somatic complaints (not feeling well due to stomachaches and headaches).
- Aggression.
- Fears.
- Children regressing back to a former behavior, such as a potty-trained child who starts to have "accidents" in bed after witnessing a fight between the parents.
- New onset or worsening nightmares and night terrors.
- Children expressing fear of being left alone by clutching onto the caregiver tightly.

Support the parents in:

- Use the same recommendations as shown for ages (0-3).
- Use *Model calming and focusing* techniques to reduce anxiety (Pearson & Hall, 2006, p. 34).

Ages (6-12). Physiological responses to trauma include:

- Preteens tend to experience internal somatic responses such as stomachaches and headaches; and external displays of verbal or physical aggression towards peers, family, or even pets.

Support the Parents in:

1. Listening to the children's' concerns.
2. Addressing questions that children ask by responding honestly and in simplistic terms.
3. Encouraging proximity of parents and children for bonding; expressing unconditional love despite episodic unacceptable behavior.
4. Offering reassurance that the adults are doing everything possible to ensure the safety of the family.
5. Determine the children's' feelings and encourage the active expression of emotion through interactive activities. (Consider use of the B-C connections and explanatory reasoning).
6. Provide the child with opportunities that will be challenging, but that are within their capability (Pearson & Hall, 2006, p. 31). Maintain positivity when a child engages in industrious tasks and offers praise.

7. Helping the child anticipate what will happen next.
8. Giving the child choices as discussed in section (ages 0-3).
9. Expecting the need to repeat things for the child.
10. Use *Model calming and focusing* techniques to reduce anxiety as needed (Pearson & Hall, 2006, p. 34).

Ages (13-18). Physiological responses to trauma include,

- Teens tend to behave similarly to preteens where in they experience similar internal somatic responses such as stomachaches, headaches or not feeling well; and external displays of verbal or physical "acting out" towards peers, family, or even pets.
- Rebellion.
- Isolation from caregivers and new onset preference for spending time with peers over caregivers.
- Experimentation with street or prescription drugs.
- Depression, suicide attempts, and other self-harming behaviors.

Support the Parents in,

1. Encouraging teens to communicate their concerns, fear, sadness or anger to avoid misunderstandings. Allowing the teen to control their personal or "safe" space and respect its boundaries (Consider the use of the B-C connections and explanatory reasoning, Pearson & Hall, 2006, p. 39-41).
2. Giving choices as age appropriate.
3. Be physically and emotionally available to your teens when they are in need of

your presence after a traumatic event.

4. Having family discussions with your teens to keep them informed and involved in family affairs and challenging times.
5. Being direct and honest when questioning your teens or providing a response to a question.
6. Engaging teens in activities such as the creative arts, music, dance, or storytelling will provide forums to be expressive. Maintain positivity when the teen engages in industrious tasks and offer praise (Pearson & Hall, 2006, p. 33). Guide the teen in the use of *Mindful Awareness and Breathing* to reduce anxiety (See websites listed at the end of the module).

Screening children. In light of the evidence presented by the ACE study, it would behoove service providers to screen and identify those children at higher risk for revictimization at the DV organization. The results of the screening may provide guidance for practice change by the DV workforce to improve outcomes and support resilience. The screening results may also allay the concern of parents who have expressed uncertainty regarding their children's' state of mental, emotional and physical health (NCTSN, 2010).

One extensively used screening instrument that has been correlated highly with a DSM-IV diagnosis of PTSD is the *UCLA Posttraumatic Stress Disorder Reaction Index (PTSD-RI).* The instrument is available by submitting a request to the National Center for PTSD using the link, http://www.ptsd.va.gov/professional/assessment/documents/100471_Assessment_

Request_Form.pdf.

The recommendation is that the assessment tool is administered within the first 24 hours after intake. If the initial intake is not feasible, then the staff should administer the screening questionnaire at the next earliest convenience of all involved (NCTSN, 2010).

Safety planning. An important step in supporting resilience involves maintaining the sense of safety for both parent and child. In taking a proactive stance, a survivor should always consider the planning of immediate and future safety, namely, determining the best time to contact 911 during a violent event or choosing a safe place to conceal funds for immediate travel and accommodations in the future (Edleson et al., 2011). Safety planning is a joint process between the advocate or DV staff member, and the mother and her children. To empower the children, it is good to involve them in all steps of safety planning; in other words, equip them well with ideas and options to protect themselves and their loved ones as needed (Edleson et al., 2011).

Vicarious Traumatization

Bearing witness to another's traumatic experience, whether it be by observing, listening to a survivors' first-hand account or providing health or mental services to manage trauma's sequelae, will undoubtedly place an emotional burden that can alter one's personal and professional functioning (NCTSN, 2010). The indirect trauma exposure and the effects on the DV staff are referred to as *vicarious traumatization;* it is what transpires when service providers commit their heart to perform in ways that ensure the best possible results for the survivors (NCTSN.org, 2016). According to the National

Child Traumatic Stress Network (NCTSN.org, 2016), the manifestations of vicarious traumatization are similar to the effects on victims, some of which include hypervigilance, despondency, inability to handle difficult situations, anger, pessimism, lack of sleep, chronic fatigue, somatic complaints, and remorse.

Strategies for prevention. The most important action in managing secondary traumatic stress is the prevention. Resilient DV organizations with an awareness of trauma and its impact, continually strive to minimize the effects of secondary stress on their staff (NCTSN.org, 2016). A plan of action for prevention may include activities of an employment assistance program within a trauma-informed organization that offers continuing education, behavioral health services, informal meetings for debriefing, wellness programs (For example, exercise, mindful awareness and good nutrition), and flextime scheduling (Volk, et al., 2008).

The National Child Traumatic Stress Network (2016) acknowledges the Foundational components of an organization risk-management policy when considering a trauma-informed system. Trauma-informed practice realizes the influence of toxic stress as a known risk factor on DV staff; trauma creates an organizational culture change as it affects the survivors' perception of a worldview and finally, the DV workforce have the capacity to translate trauma-informed knowledge into policy followed by action through practice enhancement (NCTSN.org, 2016).

How does the DV workforce benefit from working in a trauma-informed organization that promotes resiliency? Transforming your organization into a trauma-

informed, resilient organization provides the benefits to its DV staff in multiple ways, (White, 2013). The benefits include,

1. A deeper commitment and improved productivity within the organization.
2. Increased employee desire and participation in practice improvement reduce employee turnover, burnout, and absenteeism.
3. Healthier, and more resilient staff.
4. An assured sense of coworker and supervisor support.
5. Decreased negative self-perceptions and of their work.
6. Finally, a greater sense of hope, understanding, belief in the possibility of recovery from trauma and other serious challenges.

PowerPoint slides. TBD.

Handouts.

1. A list of children's storybooks that promote resilience (Pearson & Hall, 2006, 46-50).
2. *Self-Care Assessment Worksheet* retrieved from http://www.ecu.edu/cs-dhs/rehb/upload/Wellness_Assessment.pdf.
3. *ProQOL* retrieved from http://proqol.org/ProQol_Test.html.
4. *Devereaux Adult Resilience Survey, see* Addendum E.
5. *My Personal Resilience Plan*, Addendum F , adapted from Melissa Institute.org, 2007, Miami, Florida.
6. *Parents and Kids on the Road to Resilience,* Addendum G.
7. *Being Calm,* Addendum H.

Activity.

1. Free Guided Meditation sessions, UCLA Mindful Awareness Research Center, 2016, retrieved from http://marc.ucla.edu/default.cfm.
2. The Greater Good: *The Science of a Meaningful Life*, 2016, retrieved from http://greatergood.berkeley.edu/topic/mindfulness/definition.
3. *Safety planning for children and teens*, adapted from the Alabama Coalition against Domestic Violence (Acadv.org, 2016), retrieved from http://www.acadv.org/get-help/safety-tips/children/.

Video.

1. Building Resilience in Young Children and Families (10 minutes 35 seconds), Adapted from Reaching in Reaching out (RIRO website), 2016, retrieved from http://www.reachinginreachingout.com/resources-parents-introresilience.htm.
2. Sesame Street: Common and Colbie Caillat - "Belly Breathe" with Elmo, retrieved from https://www.youtube.com/watch?v=xH8TWHv0UkU.

Definitions of Terms

Compassion fatigue. A label proposed as a less stigmatizing way to describe secondary traumatic stress (NCTSN.org, 2016).

Compassion satisfaction. Refers to the positive feelings derived from competent performances as a trauma professional. The concept represented by positive relationships with coworkers inspires a feeling of accomplishment that individual achieve about clients, community, and society (NCTSN.org, 2016).

Cultural awareness. The self-examination and in-depth exploration of one's cultural and professional background (Campinha-Bacote, 1998, 2002).

Cultural competent care. Care that respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviors (AHRQ, 2014).

Cultural knowledge. The process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups (Campinha-Bacote, 2002).

Cultural skill. The ability to collect relevant cultural data regarding the client's presenting problem and accurately performing a culturally based physical assessment (Campinha-Bacote, 2002).

Cultural encounters. The process that encourages the care provider to engage in cross-cultural interactions with clients from culturally diverse backgrounds (Campinha-Bacote, 2002).

Cultural desire. The motivation of the care provider to want to, rather than have to, engage in the process of becoming culturally aware, culturally knowledgeable,

culturally skillful, and familiar with cultural encounters. Cultural desire involves the concept of caring and a genuine passion to accept differences, build on similarities, and be willing to learn from others as cultural informants (Campinha-Bacote, 2002).

Cultural Congruence. It is the understanding and application of acceptable beliefs, ideas, and practices that result in an interpersonal, social, and intercultural understanding and acceptance of differences and similarities of all peoples within a worldview (Douglas et al., 2011).

Diversity. The mixture of apparent and invisible psychological, physical and social characteristics, as well as life experience that affect our views and interaction with the world, including but not limited to age, culture, immigration status, economic status, economic class, educational experience, ethnicity, gender, language, learning style, location, mental/physical ability, nationality, political affiliation, race, religion, real or perceived gender identity, sexual orientation, and social class (PCAR, 2009). In other words, diversity can be seen as all of the things that make us similar and different. It is also important to recognize our perception of diversity and not minimize or demoralize other's personal characteristics and life experiences (PCAR, 2009).

Ethnoviolence. The violence and intimidation directed at members of ethnic groups that have been marginalized and stigmatized by the dominant or host culture because their inability or unwillingness to assimilate threaten the dominant group's entitlement to society or community resources (Helms et al., 2012).

Intimate partner, domestic and sexual violence (IPDSV). It is a community and global health issue affecting not only the abuser and the victim but also everyone around them. IPDSV is also not gender-specific.

Violence against Women. Any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (UN.org, 2016).

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Appendix A: A Message to Parents

A Message to the Parents,

None of us grew up in a perfect family. Some of us, however, grew up in very unsafe homes.
It would be helpful for us to know specifically what you experienced while growing up. It helps us to think about how to support your own parenting skills through what might be challenging times or experiences. For example, if you grew up in a household where you did not have enough to eat, will that make it harder to know how much your child should eat at any given age? If you were physically abused as a child, how will you feel or react when your toddler hits you out of frustration or anger?

It is very important to know that an unsafe or dysfunctional home is only part of anyone's story. We also know that resilience, the ability to 'bounce back', is just as important as adversity.

Following this letter is a questionnaire asking about your own Adverse Childhood Experiences (ACEs), a questionnaire about resilience and an ACE questionnaire for your child. Thank you for sharing this information with us. Your personal information will be kept confidential. We will track overall information obtained in order to make decisions about services to offer within the organization.

For more information about ACEs and the importance of resilience, the following websites may be helpful:

Acestudy.org
Resiliencetrumpsaces.or
Aceconnections.com
Acestoohigh.com

Thank you,

Administration and the DV Workforce

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you often or very often feel that ...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you often or very often feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents ever separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Resilience Score

Please answer the questions below using the following scoring guide:

0	1	2	3	4
Definitely Not True	Probably Not True	Not Sure	Probably True	Definitely True

1. I believe my mother loved me when I was little. 0 1 2 3 4
2. I believe that my father loved me when I was little. 0 1 2 3 4
3. When I was little, other people helped my parents take care of me and they seemed to love me. 0 1 2 3 4
4. I've heard that when I was an infant, someone in my family enjoyed playing with me and I enjoyed it too. 0 1 2 3 4
5. When I was a child, there were relatives in my family who helped me feel better when I was sad or worried. 0 1 2 3 4
6. When I was a child, neighbors or my friends' parents seemed to like me. 0 1 2 3 4
7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me. 0 1 2 3 4
8. Someone in my family cared about how I was doing in school. 0 1 2 3 4
9. My family, friends neighbors and friends talked about making our lives better. 0 1 2 3 4
10. We had rules in our house and were expected to keep them. 0 1 2 3 4
11. When I felt really bad, I could almost always find someone I trusted to talk to. 0 1 2 3 4
12. As a youth, people noticed that I was capable and could get things done. 0 1 2 3 4
13. I was independent and a go-getter. 0 1 2 3 4
14. I believe that life is what you make it. 0 1 2 3 4
15. There are people I can count on now in my life. 0 1 2 3 4

Total Score: _____

CYW Adverse Childhood Experiences Questionnaire Teen (ACE-Q) Teen

To be completed by Parent/Caregiver

Today's Date: _____

Child's Name: _____ Date of birth:

Your Name: _____ Relationship to Child: _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. Please read the statements below. Count the number of statements that apply to your child and write the total number on the line provided.

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box.

Section 1. *At any point since your child was born…*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked them to touch that person's private parts in a sexual way that was unwanted, against your child's will, or made your child feel uncomfortable
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box.

Section 2. *At any point since your child was born…*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/him primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was detained, arrested or incarcerated
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion
- Your child experienced verbal or physical abuse or threats from a romantic partner (i.e. boyfriend or girlfriend)

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Caregiver

Today's Date: _____

Child's Name: _____ Date of birth:

Your Name: _____ Relationship to Child: _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. Please read the statements below. Count the number of statements that apply to your child and write the total number on the line provided.

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. ☐

Section 1. *At any point since your child was born...*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. ☐

Section 2. *At any point since your child was born...*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

Comments:_____

Questions:_____

Concerns:_____

I would be interested in:

___Parenting Classes
___Parent Support Groups
___Visiting Home Nurse Programs
___Twitter Feeds: (helpful hints on parenting)
___More information on your Web Site
___Relief Nursery Services
___Other (please tell us more) _____

This questionnaire was filled out by: ___Mom ___Dad

Appendix B: Cultural Competency Communication Assessment

Helpful Tips

CULTURAL COMPETENCY COMMUNICATION ASSESSMENT

To assess how hard you will have to work to communicate in the multicultural workplace, rate your responses to the statements below. Use a scale of 1 to 5 to rate how strongly you agree with the statements, 1 being low agreement and 5 being high. If you score less than 3 for any item, think of ways you can improve your communication.

Assessment Items	1	2	3	4	5
I speak audibly and distinctly.					
I use a speech rate and style that promotes understanding and demonstrates respect for the client.					
I use short sentences, emphasizing one point or asking one question at a time.					
I use simple words and avoid jargon or slang.					
I listen as much as I speak; I do not interrupt.					
I allow extra time to communicate with someone whose first language is not mine.					
I ask victims how they would prefer to be addressed					
I allow victims and their family members to choose their own seating for comfortable personal space and eye contact.					
I avoid body language that may be offensive or misunderstood, such as sitting too close or looking directly into someone's eyes.					
I speak directly to the victim, even when using an interpreter.					
I respect silence and do not fill every gap in communications.					
I use open-ended questions or questions phrased in several ways to obtain information.					
I consider the effect of cultural differences on messages being transmitted and I check my assumptions.					
When experiencing frustration or sensing conflict in a cross-cultural situation, I ask myself, "What's really going on here?"					
I adapt my style to the demands of a situation.					
I appreciate different ways of communicating.					
I do not judge people on their accents or language fluency.					
I use the telephone judiciously.					
I try to be open and direct in giving feedback.					
I make an effort to talk about differences. I try to include people in discussions that affect them.					
I never make ethnic jokes, and I object when others do.					
I never make remarks that are "hot buttons" for women, minorities, or any other group.					

Appendix C: Cultural Care Plan

CULTURAL CARE PLAN

Client _____ ID Number_____

Gender: F_____M_____ Trans FTM_____ MTF_____ How would you like to be addressed?

_____

Culture/Ethnicity _____Acculturation: ___Traditional ___ Acculturated ___Assimilated

Religion _____ Spiritual needs_____

Preferred language _____Interpreter/Phone # _____

Able to read preferred language? _____English ability: __Understands ___Speaks ___Reads___

Client's explanation of the event

_____

Nonverbal communication patterns

_____

Etiquette and social customs

_____

Life span rituals

_____

Pain (Physical, emotional) assessment (Use of Pain Scale)

_____

Dietary assessment

_____

Medication/Herbs assessment

_____

Daily health practices and routines

_____

Psychosocial assessment

_____

Decision maker _____Relationship _____Contact Info _____

Cultural/ethnic community resources

_____

CULTURAL CARE PLAN

NOTES

Translated from Cultural Assessment and Care Planning by Narayan, M. C., 2003, *Home Healthcare Now*, *21*(9), 614.

DV Culturalogical Assessment

The following is a list of questions regarding the ethnic and cultural practices of survivors, which is useful to support their care after domestic violence. You can use all of the questions or you can choose specific questions as you deem necessary. A level of trust may need to be established with the survivor before there is a willingness to share certain information. The use of language services assist in conveying questions to gain accurate information on medical, behavioral, and social histories. Another option is to use this document as an entrance questionnaire upon initial intake that the survivor completes. It may be directed to the survivor as follows,

- Here at _____, we serve the survivors of violence from different walks of life, including people of different races, ethnicities, sexual orientations, gender identities, abilities, age, socio-economic status, spirituality and faith. Is this acceptable to you?
- The following questions are optional and will help us serve you better. Rather than make assumptions about how you identify and what services you will need, we recognize that there is power in self-identification and self-determination.

Survivor's Explanation of Violence

1. When and how did the violence begin?
2. Why do you think the problem started when it did?
3. Did you tell family or friends about what is happening to you? If not, what might members of your family/community think is happening?
4. How do you/your family/your community members think the issue should be managed?

5. Who in your family/community/religious group can help you?
6. What are your concerns regarding violence?
7. Does violence carry a stigma in your culture or is it acceptable?
8. When you are being affected by violence, do you tend to "tell the truth" or remain quiet?
9. What problems has it brought into your life? What do you think will happen?
10. What do you fear most about your situation?
11. How serious do you think this problem is? How have you managed so far?

Language and Ethnohistory

12. Tell me about any positive or negative experiences with how people communicated and cared for you in the past so that we can modify and improve our care for you now?
13. What is your country of origin?
14. How do you identify yourself culturally?
15. What ethnic/cultural group do you identify with?
16. How long have you lived in this country? What led to you come here?
17. Sometimes when people are trying to leave their country, they encounter some unpleasant experiences. Is there any experience that we should know about that would be important to your care while here?
18. What language is spoken in your home?
19. Do you speak, read, and/or understand English or another language?
20. You have a right to an interpreter. Would you like one?
21. Are there resources/equipment that you normally use to assist you with communicating?

Kinship and Social Factors

22. How would you prefer to be addressed while here?
23. Do you have other family members who live close to you? Do any of them live in the home with you?
24. Who is considered family? What impact does trauma have on your family?
25. Who is the head of the family? Who makes decisions for you?
26. Who helps when you are sick? With whom should we discuss your care? Is there someone who helps you make decisions?
27. How will family members be involved in your care?
28. What health/support services are available through your cultural community?
29. Are there others that you want to be involved in your care? Who are these persons? How would you like them to be involved?
30. Will anyone other than yourself be participating in decisions affecting your child's care?
31. Are there any barriers related to your family coming to visit you?
32. Tell me what good care means to you. In what way would you like Administration, frontline staff, direct care staff, dining staff or health care providers to care for you while you are staying with us? What can we do while you are here that will lead you to feel that you have been receiving good care?
33. Do you feel safe in your home? What have you done to feel safe? What will help you to feel safe while you are here?

Worldview

34. When looking at yourself, what does the word 'healthy' mean to you?

35. Share with me what you believe caused your situation.
36. Why do you think that your situation started when it did?
37. How has this situation affected your life and the life of your family?
38. What made you come to our shelter now?
39. It can be frightening to leave your home. How are you feeling about having to be here? What fears do you have about your situation?
40. Tell me about your feelings regarding this situation and how it might affect you as a person?

Environmental Factors

41. Are you exposed to anything in the air, water that you drink, etc. where you live or work that you believe may be harmful to you and your family?
42. Are you allergic to anything in the environment that you are aware of? (e.g., chemicals, mold, etc.)
43. Do you have the following in your home – electricity, running water/well water, indoor plumbing, stairs, etc.?
44. Do you have any special item that you have at home that would be comforting to have with you in this shelter? If so, what meaning does it have for you? If you are unable to speak for yourself, who would you choose to care for the item?

Cultural Values, Belief, and Lifeways

45. We are interested in honoring your values and beliefs. How would you like to be greeted and addressed by our staff?
46. What behaviors are expected of guests? Taking shoes off? Accepting food/drink?

47. How many meals per day do you normally eat? At what times? With whom do you usually eat your meals?
48. Tell me about the foods that you normally eat at mealtime. Perform a two-day diet recall.
49. Are there dietary patterns that may be in conflict with the plan of care (e.g., fasting)?
50. Is there potential for food/drug interactions with traditional foods?
51. What foods are thought to promote health? What foods are considered helpful when you feel sick?
52. Do you follow the cold-hot theory of disease and treatment?
53. What is your usual bedtime? Is there anything that helps you to sleep better or worse?
54. Many people have a 'routine' at home. Is there any part of your routine that you would like to keep the same, if possible, while you are here such as the time you take your shower/bath, etc.?
55. Is eye contact considered polite or rude?
56. Is personal space wider/narrower than American norms?
57. When, where, and by who can you be touched?
58. What is the meaning behind certain facial expressions and hand/body gestures?
59. Is special meaning attached to loud or whispered conversations?

Religious, Philosophical, Spiritual Factors

60. Are there any special considerations that we should know about related to persons of the opposite gender being involved in your care?

61. Tell me about any considerations that we should know about related to your religious beliefs/practices, for example, diet, prayer/meditation times, or designated spaces for prayers?
62. Is there anyone that we can call for you now to offer you spiritual/religious support?
63. Are their special rites/blessings for the sick?
64. How can we best support you spiritually while you are here?
65. Are there religious articles that you like to use, wear, or keep close?
66. Are there dietary prescriptions or restrictions that should be maintained?
67. Any valuables (if unfamiliar items are worn such as crosses, cloth bracelets/strings, charms, medicine bag, etc.)?
68. What are your feelings toward Western medications? Are they valued or distrusted?
69. What meaning does a religious or spiritual item have for you? Do you feel that your well-being will be affected if the item is removed? How?
70. What normally helps you to feel better if you are feeling sad or stressed?
71. Should discussions be direct and forthright or subtle and indirect?
72. What topics are not acceptable? Is it appropriate to share emotions and feelings? Is it acceptable to discuss reproduction, sexual, or elimination issues or to discuss the possibility of negative outcomes?
73. Do you have any restrictions related to receiving blood/blood products?

Political and Legal Factors

74. Do you have legal documents/information that we should be aware of? (Power of attorney, etc.)

Economic Factors

75. How do you normally get medications that you need?
76. Do you get financial assistance/support services for any of your daily needs?

Technology Factors

77. Do you use any equipment/technology at home to help you to maintain your health?
78. How will you get to your appointments after discharge?

Educational Factors

79. How do you believe that you learn best?

Generic Folk/Care Practices

80. Are there special rituals/practices associated with bathing, toileting, hair/nail care?
81. Are there gender/age/social class restrictions on who can help a person with trauma?
82. How important is modesty? How is modesty shown?
83. Are there special morning/evening rituals or practices that are important to you?
84. Do you seek help from anyone other than a licensed medical provider that helps you to stay well or helps you when you are not feeling well?
85. Tell me about things you do to help yourself feel better when you are feeling sick, sad, or scared.
86. Tell me about any herbal, vitamin supplements, or prescription drugs that you are taking: Dosage, frequency, and for what reason? How do you get the

supplements? Tell me about any activities that you are involved in for your health and well-being.

87. Have you taken or done anything before coming to the shelter to treat a present condition? Did it make you feel better, worse, or was there no change in how you felt?
88. Do you tend to be stoic or expressive when in physical, psychological, or emotional pain?
89. What does physical, psychological, or emotional pain mean to you?
90. What is your opinion about taking medications to relieve the pain?

Professional Care/Cure Practices

91. Where do you most often receive care when you are feeling sick or for regular checkups?
92. Are there tests/procedures/treatments that violate cultural norms?
93. In past experiences with Social Services or law enforcement, what have you found helpful, offensive, or confusing?

Children

94. What do you teach your family/children about being_____(Hispanic, Native..?)
95. What other important things do you teach your children?
96. What does your culture say about disciplining your children?
97. How do you help your children if they are sad, angry, or afraid?
98. How do you acknowledge good behavior in your children?

Degree of Acculturation

- How strictly do you adhere to the belief/values/practices of your culture of origin?
- Are you traditional (maintains ways of culture of origin)?

  Acculturated (understands and is able to move in/out of old/new culture)?

  Assimilated (has internalized the new culture's norms)?

Gender and Sexual Minority

- How would you like me to address you?

  Show awareness of diverse relationships by addressing significant others using terms such as, parents (not Mom or Dad), supports, partners (not girlfriend, boyfriend, husband or wife) or chosen family.
- How do you identify (check all that apply),

  ☐ man ☐transgender ☐FTM ☐genderqueer

  ☐ woman ☐transsexual ☐MTF ☐intersex

  ☐ other:_____
- Do you use pronouns and if so, what are they?
- What type of sleep and restroom accommodations are you comfortable with?
- Are you in need of any special hair products, foods for religious or spiritual dietary needs or a safe place for prayer with mats?
- What can we do to make you feel safe here?
- Do you take special medication for sex reassignment surgery? Are you pre-op?
- Are you in need of a follow-up with a healthcare provider while you are here with us?

Disability

- Is there anything that I need to know to provide you with the best services possible?
- What physical, sensory, and cognitive challenges do you have?
- Does anyone control your communication with others or change what you are trying to say?
- Has anyone taken or broken something that you need to be independent, for example, a cane, walker, wheelchair or respirator?
- Does anyone have legal control over your money or your decisions? What happens if you disagree with them about their decisions?
- Does anyone prevent you from using resources and support that you need to be independent, for example, vocational services, personal care attendants, disability agency support person, specialized support personnel for deaf-blind persons, readers or interpreters?
- Do you have any concerns or hesitation about using our program's services?

Translated from Cultural Assessment and Care Planning by Narayan, M. C., 2003, *Home Healthcare Now*, 21(9), 613.

Appendix D: Exploring Cultural Concepts: The Culturogram

Exploring Cultural Concepts: The *Culturagram*

Elaine Congress, D.S.W.

Keywords

Culturagram, cultural responsiveness, culturally diverse families, family assessment

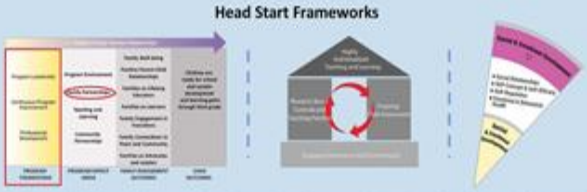
Some Research Highlights

- An important part of getting to know a family is to learn and value their multi-dimensional cultural perspective.
- The *Culturagram* is a tool that may be used to collect family data related to culture; it is especially useful for refugee and immigrant families.
- The *Culturagram* recognizes the important role of culture in understanding families.
- Staff have a responsibility to educate and help enlarge the cultural lens of other professionals in the field who are working with diverse families.

Relevant Publications

Congress, E. (2008). The culturagram. In A. Roberts, Social work Desk Reference (2nd ed.) (pp.969-973.) New York: Oxford University Press.

Head Start Frameworks



This resource highlights only select aspects of each framework and is not an exhaustive review of the frameworks or the research.

Instructions for Completing *Culturagram*

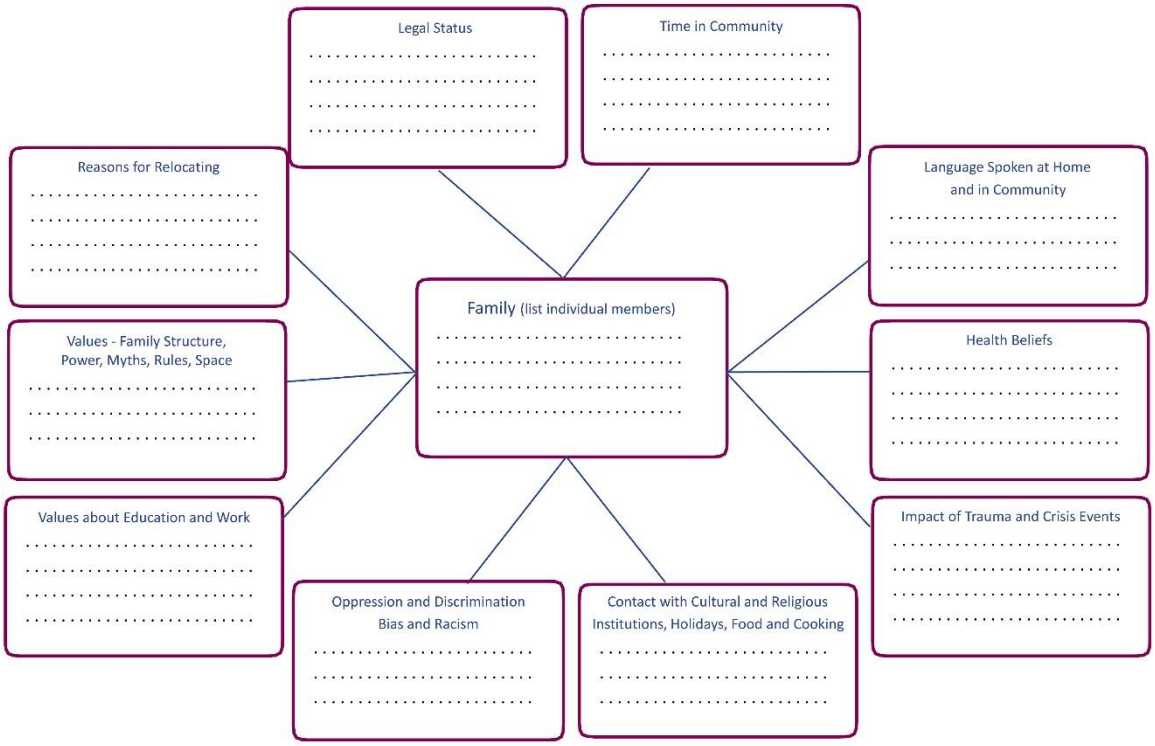
1. Form small groups to review the *Culturagram* and its 10 elements.
2. Individually think about either your present-day family or your childhood family.
3. Fill in the *Culturagram* on the lines provided. Skip the elements that don't pertain to you or your family.
4. Within your small group, share the aspects of your *Culturagram* that you feel comfortable discussing.
5. Consider the following questions:
   - What similarities did you notice among the *Culturagrams* shared in your small group? What differences did you notice?
   - How might you use this experience to increase your understanding of and responsiveness to the variety of cultures and languages represented by the families in your classroom or program?
   - What are some of the ways you might gather elements of a family's *Culturagram* without actually using the form directly with families?

Note: In practice, it is important NOT to sit with families and ask them directly about the elements of their *Culturagram* or fill out the form in front of them.

Email: NCCLR@bankstreet.edu • Toll Free: 888-246-1975 • NCCLRinfo@edc.org
Toll Free: 855-494-0331 • http://eclkc.ohs.acf.hhs.gov/hsk/tta-system/cultural-linguistic

Culturagram Screen – 2016 ***Client's name:_____ DOB:_____***

Date: _____



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Appendix E: Devereux Adult Resilience Survey

Devereux
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Devereux Adult Resilience Survey

AN INTRODUCTION

Thank you for your interest in the Devereux Adult Resilience Survey.

Authored by Mary Mackrain, the Devereux Adult Resilience Survey (DARS) is a 23-item reflective checklist that provides adults with information about their personal strengths. The information can be used to help individuals build on these strengths, such as creativity and setting limits, so that they can better cope with adversity and the stresses of daily life.

Statistical analysis shows that the DARS is an excellent tool for providing adults with an opportunity to gain valuable insights, particularly in these four areas:

Relationships: The mutual, long-lasting back-and-forth bond we have with another person in our lives.

Internal Beliefs: The feelings and thoughts we have about ourselves and our lives, and how effective we think we are at taking action in life.

Initiative: The ability to make positive choices and decisions and act upon them.

Self-Control: The ability to experience a range of feelings, and express them using the words and actions society considers appropriate.

The purpose of the DARS is not to compare individuals' scores to the population, but to give adults, more specifically teachers, the opportunity to become aware of personal strengths and areas of need. Upon completion of the Devereux Adult Resilience Survey, individuals are encouraged to use the *Building Your Bounce: Simple Strategies for a Resilient You* Adult Journal. This journal provides suggested strategies for strengthening adults' protective factors shown to support resilience.

It takes a fair amount of reflection and practice to change any negative thoughts we might have and to integrate new behaviors that are good for us. You are worth it. Even if you are already a strong, happy person you will want to continue building yourself up to maintain or increase your level of well-being.

Best wishes on your personal journey.

For questions and more information: http://www.CenterForResilientChildren.org

Devereux
CENTER FOR RESILIENT CHILDREN

Devereux Adult Resilience Survey (DARS)

by Mary Mackrain

Take time to reflect and complete each item on the survey below. There are no right answers. Once you have finished, reflect on your strengths and then start small and plan for one or two things that you feel are important to improve. For fun and practical ideas on how to strengthen your protective factors, *Building Your Bounce: Simple Strategies for a Resilient You* is a wonderful resource.

For more information about the Devereux Center for Resilient Children, including downloadable free access to the Devereux Adult Resilience Survey (DARS), please visit www.CenterForResilientChildren.org.

Items	Yes	Sometimes	Not Yet
Relationships			
1. I have good friends who support me.			
2. I have a mentor or someone who shows me the way.			
3. I provide support to others.			
4. I am empathetic to others.			
5. I trust my close friends.			
Internal Beliefs			
1. My role as a caregiver is important.			
2. I have personal strengths.			
3. I am creative.			
4. I have strong beliefs.			
5. I am hopeful about the future.			
6. I am lovable.			
Initiative			
1. I communicate effectively with those around me.			
2. I try many different ways to solve a problem.			
3. I have a hobby that I engage in.			
4. I seek out new knowledge.			
5. I am open to new ideas.			
6. I laugh often.			
7. I am able to say no.			
8. I can ask for help.			
Self-Control			
1. I express my emotions.			
2. I set limits for myself.			
3. I am flexible.			
4. I can calm myself down.			

Appendix For: My Personal Resilience Plan

MY PERSONAL RESILIENCE PLAN

Creating a Vision of the Future

In each of the following FITNESS areas, identify the specific things you plan to do in order to improve your level of RESILIENCE. How much confidence do you have that you will be able to follow through on each Resilience-bolstering Behavior?

PHYSICAL FITNESS

____ 1. Take care of my body.

____ 2. Exercise regularly.

____ 3. Get good sleep.

____ 4. Eat healthy.

_____5. Avoid mood-altering drugs, overuse of alcohol.

_____6. Manage pain (physical and emotional).

_____7. Avoid high-risk dangerous behaviors.

_____8. Other examples of ways I can KEEP PHYSICALLY FIT.

INTERPERSONAL FITNESS

____ 9. Recognize deployment changes everyone and that readjustment takes time.

____ 10. Reconnect with social supports.

_____11. Lean on others and seek and accept help.

_____12. Give back and help others. Share my "islands of competence" with others.

_____13. Participate in a social network.

_____14. Share my emotions with someone I trust.

_____15. Strike a balance between my war buddies and my loved ones.

_____16. Overcome barriers to seeking help.

_____17. Renegotiate my role at home.

_____18. Use my communication (speaker/listener) skills and my social problem-solving skills.

_____19. Use my cultural or ethnic traditions, rituals and identity as a support aide.

_____20. Find a role model or mentor.

_____21. Use community resources such as Websites, telephone hotlines.

_____22. Be proud of the mission that I served with my "Band of Brothers/Sisters".

_____23. Use pets to maintain and develop relationships.

____ 24. Other examples of ways to DEVELOP AND USE RELATIONSHIPS.

EMOTIONAL FITNESS

_____25. Cultivate positive emotions (hobbies and pleasurable activities).

_____26. Engage in an UPWARD SPIRAL of my positive emotions, thoughts and behaviors.

_____27. Make a "BUCKET LIST" of emotional uplifting activities and then JUST DO IT!

_____ 28. Show "GRIT"- - ability to pursue with determination long-term goals. (Choose hard right, over easy wrong.)

_____ 29. Use positive humor.

_____ 30. Cope with intense emotions by using opposite actions.

_____31. Give myself permission to experience and share emotions (feel sad, cry, grieve, become angry).

_____ 32. Face my fears.

_____33. Engage in constructive grieving (memorialize and honor those who have been lost).

_____ 34. Share my story and the "rest of my story" of what led me to survive (share lessons learned).

_____35. Allow myself to share my "emotional pain" with someone I trust.

_____36. Journal - - use "writing cure."

_____37. Use creative and expressive activities to work through my feelings.

_____38. Enjoy the benefits of self-disclosure.

_____39. RESTORY my life and share evidence of my RESILIENCE.

_____ 40. Take specific steps to EMOTIONAL FITNESS.

_____ 41. Change my self-talk.

_____ 42. Engage in non-negative thinking and become more STRESS-HARDY.

_____ 43. Show gratitude.

_____ 44. Other examples to improve my EMOTIONAL FITNESS.

THINKING FITNESS

_____45. Be psychologically flexible.

_____46. Use constructive thinking and consider alternative solutions/pathways.

_____47. Establish achievable goals.

_____48. Establish realistic expectations.

_____49. Look at things differently.

_____50. Use hope to achieve goals.

_____51. Be realistically optimistic.

_____52. Bolster a sense of self- confidence and self-efficacy.

_____53. Engage in benefit-finding. (Search for the silver lining.)

_____54. Engage in benefit-remembering.

_____55. Engage in downward comparison. (Consider those less fortunate.)

_____56. Go on a meaning making mission. List and share positive military experiences with others.

_____57. Engage in altruistic (helping) behaviors.

_____58. Find meaning in my suffering and move toward "post-traumatic growth."

_____ 59. Consider lessons learned from my deployment that I can share with others.

_____ 60. Be mindful- - stay in the present.

_____ 61. Maintain my "moral compass." Stick to my key values.

_____ 62. Use my Change Talk.

_____ 63.Control my self-talk.

_____ 64. Avoid "THINKING TRAPS".

_____ 65. Nurture a positive view of myself, others and the future.

_____ 66. Create a "HEALING STORY."

_____67. Other examples of ways to improve my THINKING FITNESS.

BEHAVIORAL FITNESS

_____68. Develop safe regular routines.

_____69. Stay calm under pressure. Keep my cool.

_____70. Prepare for possible high-risk situations.

_____71. Break tasks into doable subtasks.

_____72. Get unstuck from the past.

_____73. Improve my "people-picking" skills. Avoid people, places and things that get me into trouble.

_____74. Take a "news holiday."

_____75. Co-exist with my difficult memories and use positive emotions to UNDO negative memories.

_____76. Self-disclose to a trusted person.

_____77. Join a social group that gives my life a sense of purpose.

_____78. Renegotiate my role and responsibilities.

_____79. Adopt a CAN DO attitude.

_____80. Read to find comfort.

_____81. Gather information (visit websites).

_____82. Avoid making things "worse."

_____83. Continue my "journey of healing" and view setbacks as "learning opportunities".

_____84. Use my ACTION PLANS and BACK-UP PLANS.

_____85. Other examples of ways to improve my BEHAVIORAL FITNESS.

SPIRITUAL FITNESS

_____86. Use POSITIVE religious/spiritual ways of coping.

____ 87. Avoid using NEGATIVE religious/spiritual ways of coping.

_____88. Maintain HOPE.

_____89. Visit the Chaplain or some other Clergy person for assistance.

_____90. Use some form of spiritual/religious/devotional activities.

_____91. Participate in a spiritual and religious group.

_____92. Engage in spiritual/religious rituals.

_____93. Engage in commemorative services.

_____94. Forgive others and also forgive myself.

_____95. Address my "moral injuries" and "soul wounds".

_____ 96. Use my religious beliefs and traditions.

_____97. Share the spiritual lessons learned from my deployment.

_____98. Reset my "moral compass" and refocus on my core values and attributes that I brought home from my deployment.

_____99. Walk away from HATE and the desire for REVENGE and use Compassion Meditation.

_____100. Recognize that life is short and make the most of every moment.

_____ 101. Other examples of ways to improve my SPIRITUAL FITNESS.

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Appendix G: Parents & Kids on the Road to Resilience

Parents & Kids on the 'Road to Resilience'

The 'Road of Life' has many bumps, twists & turns. What do kids need to travel it with resilience?

CARING RELATIONSHIPS & POSITIVE ROLE MODELS

Caring relationships & positive role models help us steer through tough times.
Here are some ways you can build a close, loving relationship with kids around you:

- Comfort kids when they are upset.
- Ask about their feelings and thoughts. Listen with interest.
- Put yourself in their shoes. Use empathy to understand their point of view.
- Give them attention and affection. Smile, play and laugh with them.

Remember, kids copy what adults say and do. Here are some ways to role model resilience:

- Take deep breaths to stay calm and patient.
- Stop & re-think. Keep on trying. Look for positives.
- Reach out for support – everyone needs help sometimes.

SELF-CONTROL

Self-control helps us handle strong emotions, wait for things we want and achieve our goals.
Here's how you can help kids:

- Teach kids to take deep breaths to help them calm down and focus their attention.
- Help them practise waiting for what they want.
- Encourage them to keep on trying when they face obstacles and reach out for help as needed.
- Show them there are no magic solutions to problems. Solutions may take time & effort.

THINKING SKILLS

Thinking skills help us find new ways to look at situations and solve problems.
Here's how you can help kids:

- Use empathy to help kids talk about worries and frustrations. Ask - *What are you saying to yourself inside your head?*
- Gently challenge negative thinking. Help them find other ways to see the situation.
- Ask for their ideas about how to solve problems. Encourage flexible thinking.
- Help them see that most problems are temporary and have solutions.

POSITIVE OUTLOOK & OPTIMISM

A positive outlook helps us deal with challenges and be optimistic about our future.
Here's how you can help kids:

- Celebrate and share stories about the "simple pleasures" in everyday life.
- Teach kids to look for beauty in nature. Point out a beautiful sunset or the smell of a flower.
- Show them how to express appreciation every day for the positives in life.
- Help them celebrate their culture and heritage.

CONFIDENCE

Confidence helps us believe that we can overcome obstacles and solve everyday problems.
Here's how you can help kids:

- Point out their strengths. Every kid has them.
- Tell them mistakes are OK. They are part of learning.
- Offer encouragement. Help them take small steps and see their progress.
- Offer choices. Making choices helps kids feel some control and learn to make decisions.

RESPONSIBILITY & PARTICIPATION

Helping others and participating in meaningful activities strengthens and motivates us.
Here's how you can help kids:

- Give kids responsibility for doing chores that you know they can do.
- Find ways for kids to help family, neighbours or others in your community.
- Nurture their interests and hobbies.
- Encourage kids to reach out and participate in school and community activities.

Reaching IN...Reaching OUT

Appendix H: Being Calm

Children SEE
Children DO

Being Calm

**When parents are calm, children learn to calm themselves, too.
Staying calm helps us handle life's challenges.**

SHARE "being calm" with your child...

- **Do calming activities together**
  - Take deep breaths together. *"Breathe in while I count to 3. Now breathe out while I count to 3."*
  - Pretend to blow up a balloon.
  - Blow a cotton ball across a table.

- **Point out when your child is being calm**
  - *"I see that you are breathing slowly. You look calm."*
  - *"Holding your stuffed animal helps you calm down, doesn't it".*
  - *"Your face looks relaxed – you are staying calm."*

- **Talk about being calm**
  - *"Let's take some deep breaths together before we go outside."*
  - *"I feel so much better after I have taken a few big breaths."*

ASK your child about being calm...

- *"You took some big breaths in and out. How do you feel now?"*
- *"Let's think together. What are some things that help us stay calm?"*

PAUSE and THINK about calming throughout the day...

- First thing in the morning
- At bedtime
- Before and during a new activity
- When you're frustrated or anxious.
- When you are in a hurry.

AND babies and toddlers, too!

- Let your little one watch you taking deep breaths.
- Gently blow your breath out slowly into your little one's face. Then smile.
- Hold your baby chest-to-chest and breathe slowly for a few minutes – your baby will feel calmer, too.

More FREE online resources to build your child's resilience
www.reachinginreachingout.com/parents (videos, books, parent stories, articles, newsletter and more)

"If we wanted to

People of color could burn the world down for what we have experienced

Are experiencing

But we don't

How stunningly beautiful that our sacred respect for the earth

For life

Is deeper than our rage."

-*Nayyirah Waheed, Salt.*