Translating Trauma-Informed Principles into Social Work Practice

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Trauma-informed social work is characterized by client-centered practices that facilitate trust, safety, respect, collaboration, hope, and shared power. Many agencies have adopted trauma-informed care (TIC) initiatives and many social workers are familiar with its basic principles, but it is challenging to infuse these ideals into real-world service delivery. This article offers 10 trauma-informed practices (TIPs) for translating TIC concepts into action by (a) conceptualizing client problems, strengths, and coping strategies through the trauma lens and (b) responding in ways that avoid inadvertently reinforcing clients' feelings of vulnerability and disempowerment (re-traumatization). TIPs guide workers to consider trauma as an explanation for client problems, incorporate knowledge about trauma into service delivery, understand trauma symptoms, transform trauma narratives, and use the helping relationship as a tool for healing.

KEY WORDS: *adverse childhood experiences; childhood adversity; trauma; trauma-informed care; trauma-informed practices*

Clients served by social services agencies frequently have a history of childhood trauma; therefore, it is essential that social workers engage in intentional trauma-informed practices (TIPs) (Bent-Goodley, 2018; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). When clients are referred for services, the focus of intervention tends to be on immediate presenting problems rather than on early trauma (Knight, 2015). Current circumstances, however, can intersect with the legacy of past adversities. Thus, it is critical for social workers to be aware of the contributions of distant trauma to problems of daily living and how trauma-related dynamics might manifest within the helping relationship.

Situations that cause a person to feel extremely threatened and powerless can create posttraumatic stress disorder (PTSD), characterized by intrusive thoughts, avoidance of situational reminders, negative affect, and hyperarousal (American Psychiatric Association, 2013; Herman, 1997; van der Kolk, 2005). Early developmental trauma like child abuse or neglect can manifest in symptomatology other than typical PTSD; such experiences can hinder the formation of secure attachments and effective coping skills throughout life (Herman, 1997; van der Kolk, 2005). These consequences of trauma can have domino effects that bring people into social welfare systems. Trauma-informed practitioners incorporate knowledge about the neurobiological and psychosocial impacts of early adversity into their practices to ensure nonthreatening and client-directed service delivery (Bloom & Farragher, 2013; Brown, Baker, & Wilcox, 2012; SAMHSA, 2014). Empowerment and safety in a healing relationship with another human are the first steps in repairing the wounded psyche (Herman, 1997).

Although the terms "trauma-informed care" (TIC) and "trauma-informed practice" are often used interchangeably, "*practice* is more accurately applied to clinical intervention, while *care* refers to the organizational context within which services are provided to clients" (Knight, 2019, p. 82). This article briefly reviews the principles and components of TIC. Then, specific suggestions are offered for translating TIC principles into TIPs. A focus is placed on using process-oriented relational strategies to engage clients in a corrective helping relationship.

PRINCIPLES OF A TRAUMA-INFORMED FRAMEWORK FOR SERVICE DELIVERY

According to SAMHSA (2014), TIC begins by recognizing that childhood trauma is very common and can have conspicuous and less obvious impacts on physical and mental health over the life

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span. TIC involves creating systems of care in which emotional well-being is paramount, using deliberate practices that facilitate trust, respect, hope, and shared power (Bloom, 2013; Brown et al., 2012; Harris & Fallot, 2001; Levenson, 2017; SAMHSA, 2014). Guiding principles of TIC include safety; transparency; enhancing peer support; collaboration; empowerment; and awareness of cultural, historical, and gender-based trauma (SAMHSA, 2014). The cornerstones of TIC fit well within the environmental context and biopsychosocial framework of strengths-based social work (Knight, 2015; Kondrat, 2008; Mishna, Van Wert, & Asakura, 2013; Saleebey, 2011; Uehara et al., 2013).

TIC is different from trauma-specific interventions, which aim to alleviate acute PTSD symptoms and improve coping. TIC is a framework for understanding the nexus between childhood experiences and current presenting problems. By considering early trauma as a possible explanation when conceptualizing client behavior, the focus is shifted away from a focus on pathology and more toward a perspective of strength and well-being. Negative views of current functioning can then be reframed as survival strategies that emerged in response to early adversity.

TIC promotes healing by fostering an alliance of human connection to build trust and resilience. Importantly, trauma-informed workers avoid disempowering dynamics in the helping relationship because they can be re-traumatizing (Harris & Fallot, 2001; Knight, 2015). Long before we had the language of TIC, psychologist Carl Rogers described the need for therapists to offer authentic and unconditional positive regard as fundamental elements in the therapeutic encounter (Rogers, 1961). Emotional injuries require reparative relationships with helpers who follow the client's lead and work cooperatively to find the best path to recovery (Kuelker, 2019). Healing occurs through shared humanity when one feels validated, understood, and valued.

TIC emphasizes a holistic understanding of clients by thinking compassionately about problematic patterns as rehearsed responses that once helped them cope with or adapt to a threatening environment. Trauma can disrupt neurological and social development, contribute to emotional dysregulation, and alter one's sense of self and identity, manifesting in maladaptive coping and interaction styles (Bloom, 2013; Cicchetti & Banny, 2014; van der Kolk, 2005, 2006). Childhood trauma can impede the cohesive integration of memory, emotions, cognitions, and coping (van der Kolk, 2005). In a reciprocal process, traumatizing experiences inform our expectations of others, and these expectations are then projected onto the interpretation of future relationships (Rutter & Sroufe, 2000). A traumagenic childhood may hinder mastery of healthy interpersonal skills—creating a cycle of eliciting the very responses that are expected and feared (Alexander, 2013).

Adverse childhood experiences (ACEs) are a set of developmental traumas that can produce long-lasting consequences (Felitti et al., 1998). The groundbreaking ACE study conducted by the Centers for Disease Control and Prevention (CDC) in the 1990s revealed that nearly two-thirds of adults reported at least one form of early adversity in their childhood homes, and 12.5 percent reported four or more (Felitti et al., 1998). The ACE study involved 17,000 health insurance patients with higher education and income than the general population, and therefore the findings underestimate rates of childhood trauma in clinical or forensic settings and in marginalized communities (Larkin, Felitti, & Anda, 2014). The 10 ACE items include physical and emotional abuse and neglect; sexual abuse; and growing up in a home with substance abuse, mental illness, domestic violence, an absent parent, or criminality (Felitti et al., 1998). Higher ACE scores indicate a greater number of adversities and are correlated with increased risk for a spectrum of medical conditions, mental illnesses, and psychosocial problems later in life (Anda et al., 2006).

ACEs represent relational trauma, characterized by invalidation, betrayal, and attachment disruptions (Alexander, 2013; van der Kolk, 2005). Relational trauma occurs when caregivers are simultaneously needed and dangerous or unavailable (Steele, Boon, & van der Hart, 2016). Growing up in a home with chronic abuse, neglect, or other sorts of family dysfunction can introduce feelings of powerlessness at a young age (Bloom, 2013). Children might feel afraid, alone, unwanted, threatened, or ignored by people on whom they are dependent, in the very place that is supposed to feel safest. As a result, over time, a person may adopt coping strategies that are protective in the traumagenic environment but counterproductive

in other settings, and cognitive schemas of mistrust or self-blame may be embedded into interpersonal patterns (Bloom, 2013; van der Kolk, 2006; Young, Klosko, & Weishaar, 2003).

Resilience is built through corrective relationships that help alter internalized beliefs about self and others (Khanlou & Wray, 2014; Knight, 2015; Shonkoff, 2016). TIC promotes healing by reinforcing self-determination and modeling effective relational skills (Bloom & Farragher, 2013). Trauma-informed practitioners intentionally minimize potential for re-traumatization (SAMHSA, 2014), which can occur inadvertently when clinicians react to client resistance or neediness with judgment, paternalism, or rigidity (Levenson & Willis, 2019). A TIC paradigm of service delivery views and responds to presenting problems through the lens of trauma. Many agencies have adopted TIC initiatives, and many social workers are familiar with its basic principles; it is challenging, however, to translate these ideals into real-world service delivery (Berliner & Kolko, 2016).

TRANSLATING TIC INTO PRACTICE

Life experiences play a role in the development and maintenance of interpersonal patterns (Bloom, 2013). Clients and their behaviors are best understood within the context of their collective past experiences. When helpers understand trauma, they can avoid reinforcing clients' feelings of vulnerability and disempowerment by using TIPs (Goodman et al., 2016). TIPs incorporate knowledge of trauma into services by (a) conceptualizing client problems, strengths, and coping strategies through the trauma lens and (b) responding in ways that create safety, collaboration, trust, and empowerment. Trauma-informed case conceptualization links presenting problems to cognitive schemas, coping skills, and attachment styles that might have evolved in response to unresolved trauma. By hypothesizing how early relational trauma might be contributing to current interpersonal difficulties, the worker can then respond intentionally to produce corrective encounters. This can be particularly challenging when working with clients in mandated services or who present as resistant. In the following sections are some ideas for translating TIC into action using the core values of safety, trustworthiness, choice, collaboration, and empowerment (Harris & Fallot, 2001). See Table 1 for examples of TIPs.

Safety

Safe Relationships. A trauma-informed assessment can create a conundrum when trying to balance client-determined disclosure with the need to submit documentation. Many agencies require intake evaluations to be completed after an initial session, but asking pointed questions about early abuse, neglect, or family problems in a first meeting may feel intrusive or re-traumatizing to clients (Ferentz, 2015). Assessment is an ongoing process rather than a one-time event; workers must allow clients time to build trust and to share information in a way that feels comfortable. In addition to exploring earlier trauma, workers should also ask about resilience factors and the presence of protective and supportive people in someone's past and present social networks.

Helping relationships must feel safe. Safe relationships are predictable, reliable, and non-shaming. Interpersonal safety transpires when expectations are clear and consistent, and when rules are transparent and imposed impartially. However, boundaries must also be flexible enough to respond to unique circumstances without unnecessary rigidity (Najavits, 2009). The social worker's style of interaction should be genuine, nonjudgmental, and nonthreatening, with appropriately paced discussion of traumatizing events and the meaning attached to them. These engagement strategies might seem self-evident or already standard in client-centered social work (Hepworth, Rooney, Rooney, & Strom-Gottfried, 2016), but it can be challenging to maintain an empathic presence with clients who seem wary, guarded, angry, unmotivated, or resistant. Through the trauma lens, however, these characteristics can be reframed as adaptive and protective reactions to feelings of vulnerability (Steele et al., 2016).

Other clients may be inclined toward pleasing others and become passive or dependent in response to past trauma. These clients may feel that they do not have a right to ask questions or assert themselves with the social worker. Boundary crossings can occur in many subtle ways due to countertransference or overidentification with a client. We tend to think of countertransference as negative, but some clients may elicit in the social worker a desire to rescue or protect (Binder & Strupp, 1997; Teyber & Teyber, 2017). Therapy is an intimate relationship, and workers should be careful to maintain professional boundaries and not

Table 1: Trauma-Informed Practices (TIPs)

TIPs	Case Example	Non-TIC Approach	TIC Approach
Safety			
Safe relationships	Worker is told to complete an assessment within a time frame, which requires asking many sensitive questions quickly in a first interview.	Social worker sits behind a desk typing information into a computer during the first interview, asking client to "comply" with the assessment. Client seems guarded and wary.	Social worker sits with client, asking open-ended questions and validating feelings, building rapport to elicit information while allowing client to share at his own pace.
Safe spaces	Social worker tries to run a counseling group with women in substance treatment but gets frustrated with the clients' silence and resistance to meaningfully participate.	The group room is a stark room with bare walls, hard chairs, harsh lighting, and linoleum floors.	Social worker asks for some petty cash, goes to a store, and decorates the room with some inspirational posters, throw pillows, a pole lamp with softer lighting, and faux plants. The room feels warm and welcoming.
Trustworthiness			
Conceptualize through the trauma lens	A 40-year-old client was sexually abused in childhood by a trusted relative. Her parents did not believe her, causing her to doubt herself. As a young adult, she was raped at college, causing her to disengage from her peers and have few support people. The client often contacts the worker with questions in between sessions.	The worker might give in to her own feelings of wanting to rescue or nurture, indulging the client's neediness. OR The worker might become annoyed and remind the client about appropriate boundaries and set rules about contact in between sessions.	Client's traumas may have left her with difficulty trusting her own instincts, and she endlessly second-guesses her own decisions. In sessions, the worker validates the inner conflict, explores trauma-related dependency dynamics, and brainstorms with the client about how to avoid re-enacting them in the helping relationship.
Recognize that help seeking can be traumagenic	A client is applying for food assistance after losing his job.	Food assistance worker focuses only on questions about income and assets.	Worker recognizes the feelings of loss, shame, and fear that often accompany unemployment. Worker validates that it can be hard and scary to find oneself in a position of needing to ask for help, which provides hope and removes stigma.
Choice			
Avoid confrontation	Client in treatment after DUI is displaying distorted thinking and minimizing his drinking problem by insisting that drinking is legal and very common.	Client is viewed as unmotivated to change and is confronted with his unwillingness to work the program. Worker says, "You won't be successful in recovery if you aren't honest. I can't help you with problem you say you don't have."	Worker says, "Addiction can be a way to self-medicate painful emotions. I wonder if you have mixed feelings about recovery. It's hard to give up coping strategies without knowing what else to replace them with. I wonder what it feels like for you when you consider giving up drinking?"

(Continued)

Table 1: Trauma-Informed Practices (TIPs) (Continued)

TIPs	Case Example	Non-TIC Approach	TIC Approach
Coach self-regulation	A teenager was referred to the school social worker after numerous incidents of disruptive behavior in the classroom. The first thing he says to the social worker is, "Don't expect me to talk to you. I don't trust no one." Then, he gets up to storm out of the room, saying, "I can't stand this school!"	Worker tries to set boundaries by explaining choices and consequences: "If you leave the room, I'll have to report that you are not complying with your corrective action plan. You will be suspended."	Worker says, "I can see you are really angry right now, and I want to understand why. Would you be willing to sit down for two minutes and try to help me understand what happened in your class? I don't want to see you get in trouble. Can you take a few deep breaths?"
Collaboration			
Ask, don't tell	A client's children were removed from her care after it was learned that her husband sexually abused them. As an undocumented person whose husband had threatened to have her deported if she went to police, she said she felt that her best option was to try to protect the kids herself within the home.	Mother was viewed as failing to protect and told by worker that this was a naïve and irresponsible response to the problem. Worker said, "You left them at risk for being abused again."	The social worker validated the impossible dilemma of worrying that if the client reported the abuse she might not be believed, and that she might be taken into custody, preventing her from being at home to protect her children. Worker said, "Can you tell me more about how you viewed your options, and how you made your decisions about trying to keep the kids safe?"
Reframe resistance	A mother of a child with a disability seems wary and guarded, answering with one-word responses. She seems depressed and overwhelmed but lacks insight into the gravity of the situation.	Social worker views client as avoiding responsibility and unable or unwilling to provide proper care. This leads to a recommendation for foster care placement.	Social worker acknowledges the loss and stress of parenting a child with special needs. Worker wonders if mother's "resistance" is based on past negative experiences with workers who seemed judgmental and shame about her own perceived failings as a mother.
Empowerment			
Use person-first language	Labels that define or describe people based on a single behavior or problem can reinforce negative self-narrative and identity.	Using words like batterer, addict, autistic, or offender.	Put the person first: Refer to clients as a person who abused their partner, a person struggling with addiction, someone on the spectrum, or an individual who has been convicted of a crime.
Model shared power	A group member breaches confidentiality by talking about another member outside the group.	Member is told by worker that she broke the rules and will be discharged from the program. This focus on rules and consequences is designed to protect confidentiality and reinforce personal accountability.	Worker brings that member back into the group to process the breach. Worker coaches the group to discuss their feelings about the violation of privacy and explore how to handle the problem. This builds skills for empathy, healthy communication, and problem solving.

Note: TIC = trauma-informed care.

enable dependence when clients seem needy or lack confidence in themselves. Interpersonal safety can be enhanced by therapist authenticity and clear relational boundaries (Covington, 2007; Tosone, 2013).

Create Safe Spaces. Clients need both physical and psychological safety to exist from the initial point of contact (Bloom & Farragher, 2013; Brown et al., 2012). Call centers or hotlines should be staffed with pleasant and comforting voices that calm the anxiety of reaching out for help. Robotic telephone menus and automated responses, while efficient, can feel frustrating and cold without personal connection. When a receptionist or practitioner smiles and greets a client by saying, "We are glad you are here," a welcoming and engaging atmosphere is projected. Many of our clients' experiences have left them feeling demeaned, judged, vulnerable, or invisible; they might have also encountered disdain or contempt from professional helpers. When emotional safety is created from the point of entry, clients feel valued and less intimidated (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005).

Physical comfort and safety can be facilitated in innovative ways. Ideally, clients walk into a waiting room that is clean and welcoming, as opposed to one that is dingy, where toys are broken or dirty, or where furniture feels hard and institutional. A warm entry space creates a sense of serenity and sends the message: "Your comfort is important to us, because you are important." Padded seating made of material that can be easily cleaned is more comfortable than hard chairs, but still within a reasonable budget. Muted colors can be more soothing than stark white walls. Artificial plants and inspirational posters can be a way of softening a waiting room to feel warm and friendly. Hazards or risks within the physical environment can be minimized with proper lighting, disability accommodations, maintenance of the property, and security safeguards. All these strategies come together to offer a single message: "This is a comfortable environment and we won't let bad things happen here."

Trustworthiness

Conceptualize through the Trauma Lens. Traumatized people often come to services with a history of being unable to depend on others to be loyal, supportive, nurturing, or responsible (Alexander, 2013). Our earliest childhood relationships help us establish a foundation of trust when we receive consistent and responsive caretaking; when these conditions are absent, attachment and intimacy with others can be undermined (Bowlby, 1988; Erikson, 1993). Relational theories of social work propose that client patterns will be reenacted in the helping relationship, creating a parallel process that provides an opportunity for a corrective experience (Rasmussen & Mishna, 2018; Tosone, 2013). Due to early relational trauma, some clients may be understandably mistrustful and wary of others, including professional helpers. A lack of trust can be adaptive—skepticism protects the client from betrayal, which is expected based on past experiences. Trauma-informed case conceptualization considers the role that early adversity plays in client engagement challenges.

Traumagenic conditions can lead to learned helplessness or to proactive aggression. For instance, self-preservation might be displayed as antagonistic or confrontational behavior (fight response), avoidance of intimacy or self-medication (flight response), or passive and dependent patterns with difficulties setting boundaries (freeze response). These survival strategies offer personal power, relief from emotional pain, or protection, but can also challenge a worker who is trying to establish a trusting alliance. *Use of self* is a technique that workers use to experience being in a reciprocal relationship with the client; the worker can intentionally observe and genuinely address client patterns as they emerge (Knight, 2012). Trust can be enhanced by transparency and healthy boundaries, helping the client to reach a more desirable outcome through modeling and corrective interactions (Teyber & Teyber, 2017; Tosone, 2013).

Circumstances that bring clients into mental health systems are often rooted in past trauma, although other presenting problems are identified as the reason for initiating services (Knight, 2019). For instance, depression, anxiety, low self-esteem, relationship conflict, parenting concerns, employment problems, or difficulties dealing with stressors can all stem from unresolved trauma (Ferentz, 2015). Trauma symptoms can masquerade as presenting problems, and wounded attachments can manifest in troubled relationships or maladaptive coping strategies (Bloom, 2013). Ultimately, the worker can use trauma-informed case conceptualization to make connections between past adversities and

current functioning and then purposefully generate corrective strategies for intervention. Treating everyone with kindness and respect is crucial in building trust and interpersonal safety. It is simple but not always easy.

Remember That Help Seeking Itself Can Be Traumagenic. Seeking or accepting help from a social worker can be tough for clients who have learned not to trust others (Bloom, 2013). A personal crisis can leave a client feeling powerless or scared, reactivating old feelings of traumatic stress. Help seeking itself can produce feelings of vulnerability, hyperarousal, or dysregulation (Ferentz, 2015; Pattyn, Verhaeghe, Sercu, & Bracke, 2014). When the autonomic nervous system is in survival mode, clients may present as either agitated or detached, which can be misinterpreted by workers as resistance or lack of motivation.

To those who grew up in abusive or neglectful homes or chaotic communities, asking for help can seem futile or even dangerous. Thus, many clients enter our service systems with apprehension. Some clients are embarrassed to need help, which is reinforced if they encounter worker judgment or condescension. Social work bureaucracies have the potential to be oppressive and disempowering, so we want to create a therapeutic milieu that avoids moralistic or paternalistic authoritarianism (Bloom, 2013). We should also be cognizant of the many ways our clients have had limited voice and choice in their lives. This is especially true of the historical and cultural trauma commonly experienced by impoverished, minority, stigmatized, and marginalized groups (SAMHSA, 2014). Social workers can provide hope that, perhaps for the first time ever, there is more to be gained than lost by relying on others for help.

Choice

Avoid Confrontational Approaches. Confrontational methods are commonly found in programs for addictions, interpersonal violence, or mandated services, and are purportedly used to promote client accountability and challenge cognitive distortions that justify undesirable behavior (Levenson & Willis, 2019). Recognizing and altering flawed thinking are important goals of behavioral change (Miller & Rollnick, 2012). Confrontation in the service environment, however, can reactivate hyperarousal and replicate disempowering dynamics. When clients are confronted in ways that seem adversarial or threatening, a defensive posture emerges, paradoxically bolstering the client's own unhelpful ideas. When clients perceive workers as judgmental, shame and fear can be stimulated, rupturing the therapeutic alliance and inhibiting clients from being forthcoming (Binder & Strupp, 1997; Streeck-Fischer & van der Kolk, 2000). Instead, active listening and nonthreatening methods like motivational interviewing (Miller & Rollnick, 2012) can minimize the need for defensiveness, allowing clients to safely explore problems and solutions, accept feedback, and improve interaction skills. For instance, if a mandated client arrives consistently late for sessions, instead of simply confronting the tardiness, reminding about rules, or implementing consequences, the worker could inquire about why it is difficult to get there on time and explore mixed feelings about being in therapy.

Consumers of services have the right to self-determination (National Association of Social Workers [NASW], 2017), and choice involves authentic informed consent. Clients should clearly understand the risks and benefits of engaging in treatment (or not) and the limits of confidentiality so they can make informed decisions about self-disclosures. As well, choice can include asking consumers how they would like to be referred to (''What is your preferred pronoun?'') and allowing them to prioritize service planning goals (''The court requires this program, but what do you want to work on?''), which enables an internal locus of control.

Coach De-Escalation, Self-Regulation, and Relational Skills. Trauma-responsive workers pay attention to process over content so that the helping relationship becomes a tool for improving relational and self-regulatory skills (Knight, 2015; Pearlman & Courtois, 2005; Tosone, 2013). Attending to parallel process and use of self allows the social worker to respond to relational themes as they are replicated in the therapeutic encounter (Knight, 2019; Teyber & Teyber, 2017). In other words, the relationship with the social worker will undoubtedly parallel the client's other relationships, re-enacting the self-narrative and projecting expectations onto the current interaction. The social worker must internally attend to the experience of being in a relationship with the client to avoid re-creating dynamics similar to those in past traumagenic relationships (Arnd-Caddigan & Pozzuto, 2008). When the social worker can re-

spond in a corrective fashion, clients learn new interpersonal skills that ultimately enhance their relationships and overall well-being.

Programs and practitioners should help consumers to feel actively involved and hopeful about their treatment goals (Bloom & Farragher, 2013; Harris & Fallot, 2001). Helping clients gain emotional competence and self-regulation are central pathways to the self-efficacy needed to achieve goals, accomplish tasks, and respond effectively to stress or conflict (Bandura, 1977). Have you ever become frustrated with a client who doesn't learn from experience, or continually engages in self-sabotage? Clients may seem to repeatedly expose themselves to situations reminiscent of earlier distress, and this is known as traumatic reenactment (Bloom, 2013). Growing up with adversity or family dysfunction can make it difficult to observe one's inner self and become adept in managing thoughts, emotions, and impulses. If healthy coping and self-control were not taught and modeled in the early home environment, clients don't know what they don't know. Instead of expressing frustration with a client's inconsistency in controlling their impulses, the trauma-informed worker recognizes that chronic early adversity can alter the architecture of the brain, possibly compromising executive functioning and self-management.

Restoring an internal locus of control can help clients build a flexible repertoire of coping skills to be used in various situations. In some psychiatric or institutional settings, restraints and seclusion are used when a perceived threat to self or others is present. Although maintaining safety and security is important, these methods can re-traumatize people with early histories of abuse or neglect (Frueh et al., 2005). Whenever possible, de-escalation strategies can be introduced to diffuse the situation. In this way, workers can coach self-regulation and self-correction skills within a context of personal and environmental safety (Frueh et al., 2005). For instance, workers can ask questions in calming tones to assess the person's inner emotional state ("Can you help me understand what is making you so angry right now?"). Workers can validate feelings ("I hear that you felt betrayed"), avoid invasion of personal space ("I won't touch you, I just want to talk"), and give people a chance to choose from an enumerated range of appropriate behavioral options ("Would you be willing to sit down for five minutes, take some deep breaths, and try to help me understand what is upsetting you?").

Collaboration

Ask, Don't Tell. Perhaps the most important thing we can do to empower clients is avoid giving advice. This can be challenging, especially when clients are stuck or seem prone to repeating what we perceive to be poor choices. Social work engagement skills emphasize active listening and open-ended questions (Hepworth et al., 2016). This translates to a process by which workers listen with curiosity and compassion. Therapeutic engagement begins with conveying that the worker is interested in understanding the client's unique experience and perspective. This may seem like standard practice, but from the trauma perspective, it involves an intentional effort to make sure clients feel respected, valued, important, and involved: "I'm really interested in getting to know you and I need your input!"

By asking questions, we collaborate with our clients to define their own goals and the means for achieving them. When clients are empowered to view their problems as manageable and their goals as realistic, we offer hope that the self-improvements they desire are possible. By asking rather than telling, we honor autonomy and self-determination, which allows the client to prioritize goals and evaluate options in a meaningful way (Saleebey, 2011). The worker becomes a coach, partnering with the client to model planning and decision-making skills while allowing the client to direct the process. This fosters the empowerment that is crucial in TIC and avoids the re-traumatization that can occur when social workers are authoritarian.

Reframe Resistance. Through the trauma lens, client problems are viewed as coping strategies that may stem from surviving a traumagenic childhood, and workers can begin by asking, "What happened to you?" instead of "What's wrong with you?" (SAMHSA, 2014). Clients' schemata about self and others are shaped by the meaning they have attached to their experiences. These perceptions are projected into expectations of others and inevitably reenacted in the helping relationship (Pearlman & Courtois, 2005; Tosone, 2013). Survivors of ACEs may be inclined toward mistrust, anxiety about being judged, or avoidance of conflict. They

may be simultaneously deferential, fearful, and resentful of authority figures. Alternatively, they may compensate for feelings of vulnerability by displaying hostility or aggression. A client with unresolved trauma may misperceive environmental cues as threatening even when no real danger exists. Thus, client hyperarousal might present as resistance or lack of motivation for change.

Resistance can be reframed as ambivalence, reflecting a simultaneous struggle between a genuine desire for change and the need to maintain what is familiar. It is difficult for anyone to give up coping strategies without knowing what will replace them, especially when they have served protective functions. We may sometimes doubt that a client is being honest with us or wonder why clients sabotage success if motivation truly exists. The social worker should expect and embrace resistance and provide an accepting and safe environment for exploration and reflection about the pros and cons of change.

Empowerment

Use Person-First Language. Disparaging or stigmatizing labels can become incorporated into one's personal narrative and self-concept (Goffman, 1963; Maruna, LeBel, Mitchell, & Naples, 2004). When an individual adopts assumptions made by others and then behaves in a way that conforms to those notions, it becomes a self-fulfilling prophecy (Paternoster & Iovanni, 1989). External messaging from others forms our "looking-glass self" by which we internalize and construct a social identity (Cooley, 1902). Words that are negative or pejorative ignore strengths-based principles and reinforce stigma.

The NASW (2017) *Code of Ethics* strongly values personal dignity and worth, and requires us to use respectful and nonderogatory language to describe those with whom we work. The American Psychological Association's (2020) publication manual guides us to use neutral language that puts the person first. Person-first language separates the behavior from the person and avoids defining people in ways that categorize or stereotype (Willis, 2018). For instance, social workers should avoid labels like "offender" or "junkie," instead describing a client as a person who has committed a crime or struggled with addiction (Robinson, 2017). Instead of saying, "He's bipolar" or "She's an abuser," person-first language would state, "He is diagnosed with bipolar disorder" or "She is engaged in abusive behavior."

Neutralize Power Struggles and Model Shared Power. It is important to neutralize power differentials between practitioners and consumers. There are many subtle and unintended ways that power dynamics can intrude in a helping relationship. Because past relational trauma often involved betrayal by someone in a caretaking or authority role, the potential for re-traumatization within social work practice must be carefully avoided (Pearlman & Courtois, 2005; Tosone, 2013). Social workers are often viewed as authority figures, so it is important to model transparency and fairness. Say what you mean and mean what you say. When social workers make mistakes, we should take responsibility, apologize when appropriate, and correct our actions, modeling permission for imperfection along with accountability and humility.

Some survivors may have learned to please others, avoid conflict, passively comply with authority figures, or acquiesce to professionals. On the other hand, negative countertransference can lead practitioners to respond to challenging clients in a dogmatic, coercive, or rejecting fashion (Binder & Strupp, 1997; Teyber & McClure, 2000). This creates a rupture in the therapeutic alliance. "Bullying the bully" can reenact traumatic experiences, and clients might resort to maladaptive strategies to gain the upper hand in a power struggle. Instead, social workers can model shared power skills such as cooperation, negotiation, dialogue, perspective taking, and compromise. By being aware of our own reactions and intentionally avoiding rigid responses, we demonstrate how to respect the viewpoints of others and collaboratively resolve conflict. Our therapeutic demeanor says, "I want to listen to you and understand your experience, but I have no need to win a debate or get into a power struggle with you." Shared power becomes a transformative experience.

SUMMARY AND CONCLUSION

When social workers provide emotional safety and acceptance in the helping relationship, an atmosphere of trust can be established (Elliott et al., 2005). Putting TIPs into action enables trust, respect, collaboration, compassion, and genuineness. These corrective elements of TIC contribute to a repaired sense of value and self-worth that might have been damaged as a result of early relational trauma; they provide hope that trustworthy and compassionate others exist. Regardless of the problem, client population, or intervention, when we

listen with curiosity and kindness, we help our clients feel the power of human connection. Through a healthy helping relationship, we model respectful boundaries and shared power, allowing both parties to collaborate on goals and assert needs in appropriate ways (Knight, 2015). By viewing client needs through the trauma lens, social workers avoid replicating dismissive or disempowering dynamics in the helping relationship. By doing so, we help clients cultivate self-advocacy and self-efficacy skills that foster healthier psychosocial functioning. Through trauma-informed case conceptualization and trauma-responsive interventions, we can partner with our clients to construct a new narrative that can transform lives. SW

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