



NAVIGATING DIFFICULT SITUATIONS IN PUBLIC LIBRARIES

The PLA Guide to
Trauma-Informed De-Escalation

Margaret Ann Paauw



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INTRODUCTION

THIS BOOK IS AN essential guide for librarians looking to create a safe and welcoming environment for patrons from all walks of life. It provides practical strategies for de-escalating difficult situations in a trauma-informed way and guidance on creating a trauma-informed library culture. The book utilizes the framework from *A Trauma-Informed Framework for Supporting Patrons: The PLA Workbook of Best Practices* with a focus on building micro-skills that are designed to help people who work in libraries handle difficult situations in a trauma-informed way.

SURVEY SAYS . . .

As a component of this book, the Public Library Association polled librarians throughout the United States about their experiences and comfort levels with navigating difficult situations in their libraries to better guide the content of this book. The survey included multiple-choice and open-ended questions. Some of the main findings included the following:

- 97.5 percent of respondents reported that they wished there were more resources for navigating difficult situations in libraries
- 55 percent of respondents reported that they didn't feel their library provided enough resources for them to feel confident in navigating difficult situations that arise in their library
- 70 percent of respondents reported that incidents that require de-escalation seem to be on the rise

When speaking with librarians, library staff, and library administration, these numbers appear to reflect the conversations we've had here at PLA as well. The fact that people who work in public libraries feel that they don't have enough resources and that these issues are increasing drove the idea to write this book. PLA is hopeful that the material in this book can contribute to filling the gaps in resources available.

HOW TO USE THIS BOOK

This book builds on the trauma-informed framework and strategies discussed in *A Trauma-Informed Framework for Supporting Patrons: The PLA Workbook of Best Practices*. We'll use this framework to work through common scenarios and learn how to actively engage in trauma-informed

work with a focus on de-escalation. You can use this book on its own or in conjunction with *A Trauma-Informed Framework for Supporting Patrons*.

This book also does not have to be read in order. We certainly encourage reading chapters one and two that provide an overview of the trauma-informed framework first; however, if you feel that you already have a good understanding of this and want to dive straight into de-escalation techniques and practices, go for it!

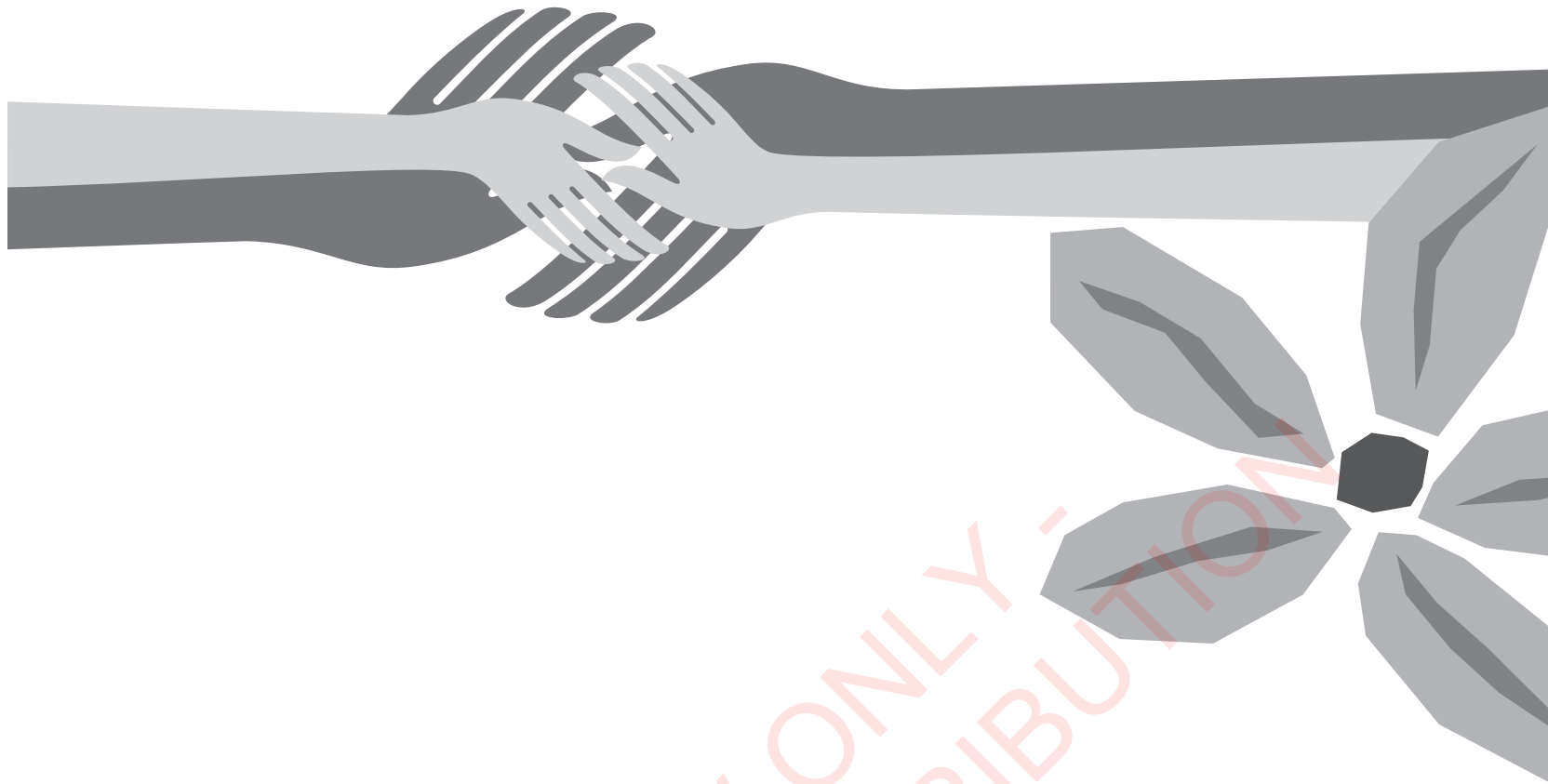
Lastly, we highly recommend taking the time to work through the activities included in this workbook. Each chapter consists of accompanying activities, handouts, and worksheets to build upon the practices introduced in this book. The activities are designed to solidify the material learned as well as to provide an example of how to consider each concept. Further, part of engaging in trauma-informed work is participating in reflection. These activities can all be used as great tools for reflecting on situations, how you handled them, things you can consider for next time, and so on.

All the worksheets and handouts in this book are available to download at alaeditions.org/webextras.



CONTENT ACKNOWLEDGMENT

In discussing how to navigate difficult situations, we want to acknowledge that the content in this book is tough. Trauma can be difficult to talk about. Thinking back on scenarios that have been scary is also very difficult to reflect on. Many of you will be pushed out of your comfort zone, and we encourage you to embrace this content; however, if you need to pause and come back or take some time, please do so. Again, this content doesn't need to be read all at once or in order. After any discussion of difficult material, practicing self-care is important. If you are able, take a walk, have a treat or something to eat, pet your cat, do whatever you can to refill your cup. Especially if you are reviewing this content as part of your workday, take a break before engaging in your next task.



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PART I

**UNDERSTANDING
TRAUMA AND
MENTAL HEALTH**

available at alastore.ala.org

Understanding Trauma

DEFINING TRAUMA

The words *trauma*, *trauma-informed*, and *PTSD* (post-traumatic stress disorder) are thrown around a lot. Because it's important for us to all have the same understanding of what these mean, the following are the definitions we will be continuously referring to in this book (also provided in table 1.1).

Trauma is witnessing or experiencing an event that caused severe emotional and/or physical harm, including something that was life-threatening—or perceived as being life-threatening. Traumatic experiences are wide-ranging and can affect people differently. Some people may be exposed to a traumatic event but are able to cope better than others. Some people go on to develop post-traumatic stress disorder (defined below) and others do not. Some people might have witnessed a trauma versus experienced it themselves; this is called *secondary trauma*, which we will expand upon later in this chapter.

Therefore, when we say *trauma-informed approaches*, we mean any approach to interacting with someone that incorporates an understanding of trauma. Again, our definition is important because *trauma-informed care* is a specific practice used in clinical or medical settings that has evidence-based, empirical backing. Because we are in libraries and not in hospitals, we take the important—and science-based—backings of trauma-informed care but tailor them to our work in libraries, making them trauma-informed approaches. See how much language can matter!

Post-traumatic stress disorder (PTSD) is a psychological disorder as outlined in the book that mental health practitioners use to make diagnoses: the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], 2013). This book provides criteria that need to be met in order to make a diagnosis of a psychological disorder. Later in this book, we will talk about various common mental disorders, so keep this book in mind when you get to that section. We particularly want to point out the difference between trauma and PTSD, because not everyone who has experienced or witnessed a trauma goes on to develop PTSD. The criteria

for a diagnosis of PTSD largely depends on whether symptoms (such as nightmares, flashbacks, hypervigilance, etc.) interfere with a person's ability to function in their daily life (APA, 2013).

Another term that is commonly thrown around is *trigger* or *triggered*. A trigger is a situation, place, or thing that reminds someone—whether consciously or not—of a traumatic event. Sometimes, this can cause one to react as if they were being exposed to that trauma again. In other words, something happens, and they feel as if they are reliving that trauma. Similarly, *re-traumatization* is when someone who has been traumatized in the past faces a similar traumatization. A large part of incorporating trauma-informed practices in the library is to prevent re-traumatization from occurring.

TABLE 1.1

Definitions of trauma

Term	Definition
Trauma	Witnessing or experiencing an event that caused severe emotional and/or physical harm, including something that was life-threatening—or perceived as being life-threatening.
Secondary trauma	Witnessing a trauma versus experiencing it firsthand.
Post-traumatic stress disorder	A psychological disorder that interferes with a person's ability to function in their daily life as a result of trauma.
Trauma-informed approaches	Any approach to interacting with someone that incorporates an understanding of trauma.
Trauma-informed care	A specific practice that is used in clinical or medical settings that has evidence-based, empirical backing.
Trigger/triggered	A situation, place, or thing that reminds us—whether consciously or not—of a traumatic event.
Re-traumatization	When someone who has been traumatized in the past faces another similar traumatization.

WHAT DOES TRAUMA LOOK LIKE?

Now that we've defined some important terms, we can explore what trauma can look like, particularly in a library setting. The list that follows includes some common symptoms of trauma people might experience. While reading these descriptions, think back on where you might have seen someone experiencing the following and add it to worksheet 1.1.

Hypervigilance

Definition: Hypervigilance is a state that someone can enter to protect themselves by being overly cautious and hyper-aware of their surroundings. When someone has experienced a trauma, they can become sensitive to what

exactly is going on around them to determine whether a threat is present or not. Hypervigilance serves the purpose of protecting oneself by being “on guard” at all times to avoid something that might cause them harm.

In the Library: Hypervigilance in the library could be someone pacing, getting up and looking around a lot, scanning the library looking for danger, and so on.

Nightmares or Sleep Disturbances

Definition: We all know what nightmares are, and the vast majority of people have nightmares throughout the course of their lives. However, in trauma, the content of these nightmares is generally about the trauma that occurred. People who have experienced a trauma might wake up in the middle of the night because of a disturbing nightmare, have night sweats, scream or move in their sleep, or have difficulty falling asleep or staying asleep.

In the Library: Sometimes people fall asleep in the library. This could be for a variety of reasons. Maybe they are experiencing housing insecurity and do not have access to safe or consistent sleep. Maybe they are on a new medication. Or maybe they simply didn’t sleep well the night before and dozed off. Sometimes when people sleep in the library, we have a hard time waking them up (if that is our policy, though we do suggest revisiting those policies to be more equitable and trauma-informed). If someone who has experienced a trauma is woken up, we might be engaging their startle response, and they could be very upset. Again, this is a reaction that in essence is attempting to keep someone safe, so when being woken up they might immediately feel the need to protect themselves against potential harm.

Flashbacks

Definition: Sometimes people who have experienced a trauma get flashbacks of the traumatic event in which they feel as if they are suddenly back in the moment to when they were in danger. This experience can consist of images or situations being replayed in the brain. Flashbacks can occur at any time, though it can be common to experience a flashback when someone has been triggered.

In the Library: When someone is experiencing a flashback, they might not exactly be present. When flashbacks occur, the individual may be re-experiencing their traumatic event in real time, which often activates their stress responses. It can also look like a patron is “out of it” or not being fully engaged or aware of their surroundings.

Dysregulation of Stress Response

Definition: Trauma can cause our stress response (fight, flight, freeze, fawn) to become activated at times when there may not actually be a real threat present. This is also used in an attempt to protect oneself.

In the Library: This symptom is something that we see a lot in the library. Someone might go straight into fight mode when confronted with something seemingly as simple as enforcing a rule. The enforcement could trigger someone into thinking that they are threatened because of prior experiences. To use the example of sleeping again, we might think that waking someone up is not a big deal, but maybe that person has a history of living on the streets where they were woken up in the middle of the night by people trying to harm them. When they are woken up in the library, their stress response is activated and tells them to go into fight mode, because that's what they would do when woken up while living on the streets. Of course, being woken up in the library and on the streets are two different scenarios, but their brain might be telling them that they are the same.

Intrusive Thoughts or Images

Definition: Trauma can cause someone to become consumed in thinking about the trauma in an attempt to reprocess it. Intrusive thoughts or images are when someone is not able to put those thoughts or images in the back of their mind and are only able to think about things related to the trauma. Similar to flashbacks, intrusive thoughts or images can occur at any time, whether the person is triggered or not.

In the Library: People who have experienced a trauma and are consumed by intrusive thoughts or images might seem distracted or on edge. Sometimes being inundated with intrusive thoughts or images can be frustrating. If someone is trying to work on a task or get something done but their brain keeps redirecting them to think about something horrible, they might be frustrated. Of course, there are many reasons someone might be frustrated, but by adopting a trauma-informed framework, we consider the many different reasons that might be attributed to someone being frustrated.

Symptoms of Depression and/or Anxiety

Definition: When people experience a trauma, symptoms of depression/anxiety may be present, including persistent feelings of worry or sadness as well as sleep disturbances, appetite disruption, feeling sore or in physical pain, nervousness, fatigue, restlessness, and sometimes agitation. In cases of chronic depression or anxiety, thoughts of suicide may occur.

In the Library: We certainly are not going to attempt to diagnose or analyze whether or not our patrons have depression, anxiety, or even PTSD, but we do see patrons who come to the library who might be nervous, agitated, or even present with thoughts of hurting themselves. Sometimes, when we have regulars we know really well, these symptoms can be more apparent if we notice changes in their baseline.



WORKSHEET 1.1

What Does Trauma Look Like in the Library?

In this activity, reflect on how you might have seen symptoms of trauma play out in the library. For each sign of trauma, write how you may have seen this in your work. Reflect on as many instances as you can remember.

	Definition	In the library
Hypervigilance	When someone enters a state of being overly cautious and hyper-aware of their surroundings to protect themselves.	1.
		2.
		3.
Nightmares or sleep disturbances	When people who have experienced a trauma wake up in the middle of the night because of a disturbing nightmare, have night sweats, scream or move in their sleep, or have difficulty falling asleep or staying asleep.	1.
		2.
		3.
Flashbacks	When someone who has experienced a trauma feels as if they have "flashed back" to the moment of the event.	1.
		2.
		3.
Dysregulation of stress response	When one's stress response (fight, flight, freeze, or fawn) becomes activated when there isn't a real threat present.	1.
		2.
		3.
Intrusive thoughts or images	When someone becomes consumed by thoughts or images related to their trauma.	1.
		2.
		3.
Symptoms of depression and anxiety	When someone experiences symptoms of depression or anxiety after a trauma, including persistent feelings of worry or sadness, sleep disturbances, appetite disruption, feeling sore or in physical pain, nervousness, fatigue, restlessness, and agitation.	1.
		2.
		3.

TYPES OF TRAUMA

We used to think that trauma was something that could happen only to veterans or during wartime, but we now know that there are many different types of trauma besides combat-related traumas. There are three main categories of trauma: *timeline*, *time-limited*, and *timeless* (table 1.2). *Timeline trauma* is a singular incident or event that can be marked on a calendar. Examples of this can include the day a car accident occurred, a loved one died, or an injury or assault occurred. Sometimes these can be referred to as “anniversaries” of a traumatic event. *Time-limited trauma* is a series of traumatic events over a specific period of time during which adversity and stress increase over a number of months or years in response to collective stressors. For example, COVID-19, this pandemic we’ve all lived through, has been a collective trauma. There were times when we were socially isolated, when we lost friends and relatives and weren’t able to grieve together. Similarly, natural disasters are also examples of time-limited traumas. Think back on some of the hurricanes in southern parts of the United States over the past decade or so. Those were collective, time-limited traumas in which those communities had to rebuild their neighborhoods for years to get back to normal. The hurricane may be something that was marked on a calendar, but the collective stress and adversity lasted much longer. Combat and wartime, community violence, and homelessness are also examples of time-limited traumas, as they are often limited to a period in time but also are traumatic experiences. Lastly, *timeless traumas* are traumatic experiences that are systematic and occur on a larger, societal scale, such as racism, homophobia, sexism, transphobia, xenophobia, and so on. All of these issues are ongoing and repetitive, making them timeless. Experiencing racism, for example, can be traumatizing because it alters one’s sense of safety in the world and in one’s life. Racism isn’t just one experience—it’s an inescapable part of daily life based on how cultural, political, and societal systems of oppression are embedded in the United States.

TABLE 1.2

Types of trauma

	Timeline	Time-limited	Timeless
Definition	A singular traumatic event that can be marked on a calendar	A series of traumatic events over a specific period of time	Systematically traumatic experiences
Examples	<ul style="list-style-type: none"> ▪ Car accident ▪ Unexpected death of a loved one ▪ An injury ▪ An assault 	<ul style="list-style-type: none"> ▪ Pandemic ▪ Natural disaster ▪ Combat/wartime ▪ Community violence ▪ Homelessness 	<ul style="list-style-type: none"> ▪ Racism ▪ Homophobia ▪ Transphobia ▪ Xenophobia ▪ Sexism

HISTORY OF TRAUMA

The earliest mentions of symptoms of trauma are from historical documents and literature from as early as 2,000 BC as well as biblical scriptures (Reyes et al., 2008). In some sections of the Christian Bible, soldiers are described as returning from battle not as themselves. It was believed that soldiers experiencing these symptoms should be removed from the frontlines in fear of contagion (Crocq & Crocq, 2000). If you are reading this and are a librarian, you are likely familiar with the *Epic of Gilgamesh*, which is considered the oldest surviving work of literature. In this epic poem, Gilgamesh witnesses his friend's brutal murder. The epic describes Gilgamesh experiencing symptoms of trauma such as disruption of dreams and extreme grief. This has been identified by historians as one of the first mentions in literature of psychological distress from a traumatic experience (Reyes et al., 2008).

After industrialization, there was a huge rise in symptoms of PTSD, specifically following train derailments and crashes, as they caused many deaths and a large amount of destruction. People even called these symptoms “railroad spine” as they believed, like many things, that the cause was medical, not psychological (Williams-Searle, 2009). Medical scientists thought that these symptoms were rooted in spinal injury, a common injury among people who were in accidents caused by train crashes. Psychology was just emerging as a field of study at this time, and any sort of ailment, physical or emotional, was still thought to have been caused by something in the body. Interestingly, we now know that there are many overlaps between mind and body, and through advances in science we're able to explore these relationships more carefully.

Throughout World War I and II, trauma was beginning to be reconsidered as psychological versus physical, though the debate remained constant. At one point trauma was thought curable once soldiers were sent home from war—in other words, removed from the traumatizing environment. Because of this, many did not receive any treatment, as simply being removed from the environment was the cure (Stagner, 2014). Similar to what was noted in the Bible, PTSD was still thought to have some component of contagion. In addition, shell shock was seen as a moral weakness or failure and compared to the psychiatric disease of hysteria, a diagnosis at the time given only to women. Further, our early understanding of PTSD was thought to have happened only to veterans during wartime. Terms like *shell shock*, *soldier's heart*, and *war neurosis* were used to describe PTSD in veterans (Crocq & Crocq, 2000). We now know that PTSD can be the result of many different types of traumas or events, not only combat.

Besides being removed from the frontlines of war, the first treatments of PTSD included electroconvulsive therapy or shock treatment, lobotomies, and insulin-induced comas (Crocq & Crocq, 2000). During World War II in particular, these treatments were developed and utilized to get soldiers ready to return to war as quickly as possible. An earlier version of the diagnostic and statistical manual of mental disorders removed PTSD, as it was thought

to occur only during wartime. There have been many different iterations of PTSD diagnosis throughout the years, but most recently, the diagnosis of PTSD involves experiencing symptoms to the extent that they interfere with day-to-day functioning.

Today, our understanding of trauma and PTSD is very different. They are multidimensional and don't happen just to veterans. Further, it is understood as purely psychological, not physical. Treatments for trauma and PTSD generally consist of psychotherapy, though these treatments can be hard to access and slow to show results. Though we have a better understanding of trauma now than throughout history, unfortunately, much of the stigma and attitudes surrounding symptoms of trauma are still seen as a moral failing.

RESPONSES TO STRESS

We *all* have responses to stress. Our natural stress responses are evolutionary mechanisms set in place to protect us. Our stress responses can be activated when we perceive a threat or are confronted with a triggering or unsafe situation. Because our mind and body are so connected, these responses can be manifested physically and emotionally. Again, when someone has experienced trauma, their stress responses can be activated quickly and sometimes in situations where they might actually be safe but still perceive a threat based on past experiences.

Responses to stress fall under four main types: *fight*, *flight*, *freeze*, and (more recently added) *fawn*. Our *fight* response is when we become physically reactive in the face of danger, as in attempting to fight off the threat. Some emotional responses in this response can be irritability, anger, and frustration. Our *flight* response is when we attempt to leave, flee the scene, or physically remove ourselves from a situation. Some emotional responses for flight can be panic and worry. When we *freeze* as a stress response, our bodies and minds shut down. Physically this can look like collapse and emotionally can be disassociation. Lastly, *fawn* is to respond to stress by avoiding a conflict through people-pleasing or smoothing things over at the expense of one's self and emotions and boundaries. In addition, sometimes people who respond to stress by fawning can lose their sense of autonomy in an attempt to avoid the conflict. View the list of stress responses in table 1.3 and complete worksheet 1.2 to determine your type of stress response.

WINDOW OF TOLERANCE

In addition to having a stress response, everyone also has a window of tolerance. Our window of tolerance is the zone in which we function the best and feel most comfortable, in control, functioning, healthy, and able to handle things that come our way. When we experience stress or are triggered, we can leave our window of tolerance and experience either hyper-arousal or

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