A TRAUMA-INFORMED APPROACH TO LIBRARY SERVICES

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Preface

The idea for this project began as an article and then expanded into a book. I've always found inspiration for new library customer service models from outside the profession and have thought about ways to adapt them to our operations. New approaches to customer service in libraries, and in all service industries, are popular and needed because they identify new practices and help us develop systems that serve our library patrons where they are. When I say "where they are," I mean at the point of need, but I also mean where patrons are personally and at what level they are comfortable accepting our help. Some libraries excel at customer service, while others fail. There are various reasons for this. It may be an individual library staff problem, or it may be due to the operational or organizational climate. A trauma-informed framework can help us build empathy for those whom we serve at the individual staff level, as well as investing empathy within our operations and throughout the organization.

In the last few years, graduate and undergraduate students with whom I've worked have exposed me to trauma theory, mostly in their need for articles to support papers and assignments in nursing. Over the course of the last two or three years those requests for help expanded from students and faculty in psychology, and then in social work, education, and public health. Many of those research requests came from students working with faculty in those departments because East Tennessee State University's (ETSU) faculty are

well-grounded in adverse childhood experiences (ACEs) and trauma-informed care (TIC). As a member of our Women's Studies Program's Steering Committee, I was asked to moderate a panel on feminist pedagogy at the Southeastern Women's Studies Association's annual conference at Clemson University in 2018. While there, the department's administrative assistant posed questions to participants on independent panels about whether or how their work was trauma informed. She and the program director for ETSU's Women's Studies program wanted to bring trauma-informed practices to a higher education setting where we serve a population of students who have experienced childhood trauma. They invited me and other Steering Committee members to the Highlander Research Center in New Market, Tennessee, for a summer retreat, "Trauma-Informed Care & Changing the Narrative of Gender-Based Violence on Campus and in the WMST Classroom," where one of our social work faculty members educated everyone about ACEs and trauma-informed philosophies.

From then on, my awareness of childhood trauma, ACEs, and resilience skyrocketed. I read scholarly articles and popular books. I watched TED Talks. I attended more trauma-informed care workshops, self-care workshops, and the like until I was saturated in the topic's philosophy and practices.

Naturally, I wondered how effective a trauma-informed approach might be for making improvements to customer service in libraries. An awareness of ACEs and childhood trauma increased my empathy for everyone I help in the library, and frankly, all of humanity. It is my hope that sharing information about this framework with library staff can increase their compassion and responsiveness in the areas of customer service. But trauma-informed care also holds promise for organizational transformation, as well. In fact, an objective of trauma-informed care moves beyond awareness and education and into organizational systems and transmitting the framework via institutional policies, practices, and procedures.

While every library may not be ready for these changes at the organizational level, an awareness of trauma-informed care by individuals can help nudge libraries in that direction. Wanting to change and improve our libraries' customer services is an ongoing objective. Transforming that urge and passion into action can be difficult, however. This book will give library staff ideas for small ways they can change their thinking, as well as ways to change their personal practices of librarianship and customer service in pursuit of these goals. Change can come from above, from the middle, or from below. A commitment to small but meaningful personal changes can pay off in large ways. However, for sustainable and universal adoption of the TIC framework, leadership must buy in. Therefore, this book is for both individuals and organizations.

In part I of this book I will explain psychological trauma and adverse childhood experiences, trauma-informed approaches to services, trauma-informed care and libraries, and the trauma-informed built environment. In part II I will address the six key principles of trauma-informed care: safety; transparency and trustworthiness; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues. In part III I will discuss assessing organizational readiness, the library as sanctuary, building a trauma-informed library workforce, long-term planning for trauma-informed services, and short-term solutions for trauma-informed services.

Please note that some people are very opposed to identifying anything psychological as *trauma*. Some professionals and scholars only recognize trauma as experienced in war zones. They don't recognize that domestic and family violence can create as much or more post-traumatic stress disorder (PTSD) in survivors as wartime experiences can. Likewise, some institutions are careful with their language. Rather than use *trauma*, Harvard University's Center on the Developing Child uses the term *toxic stress* to identify the same dynamic. Still other institutions and authorities use the term *traumatic stress*. But all three of these concepts are synonymous. And all three of them use adverse childhood experiences as a baseline for understanding the dynamic, explain the same neurobiological adaptations the brain and body make to childhood trauma, and discuss the same interventions that lead to resilience and positive lifelong outcomes.

PART I

Adverse Childhood Experiences and Trauma-Informed Care

1

Trauma and Adverse Childhood Experiences

When we think about psychological trauma, many of us default to thinking about overt, external examples, like the emotional trauma suffered by war veterans or the survivors of natural disasters. And it is true that trauma was traditionally classified as resulting from events outside the range of normal human experience. But Mark Epstein (2013) reminds us that trauma isn't just what happens after Hurricane Katrina, school shootings at Virginia Tech, or a terrorist incident. Trauma happens to everyone. He says that the undercurrent of trauma informs ordinary life.

WHAT IS TRAUMA?

So what exactly do we mean by the term *psychological trauma*, or simply *trauma* (as it is now often referred to)? Psychological trauma is damage or injury to the psyche that results from an extremely frightening or distressing event or experience. These events and experiences usually involve a threat to our psychological or physical well-being. Trauma can result from a single painful event, a prolonged event, recurring events, or a series of ongoing, relentless stresses. The

trauma typically occurs due to an overwhelming amount of stress that exceeds a person's ability to cope or to integrate the painful emotions involved.

Life-threatening events like combat or natural disasters have traditionally been associated with trauma, and particularly with PTSD, but trauma resulting from childhood abuse or neglect, domestic violence, or rape is far more common in the population and occurs on a larger scale. Children are especially susceptible to emotional trauma because they are generally more vulnerable and lack the coping skills and capacities of adults. Traumas sustained during childhood are known as *adverse childhood experiences* or ACEs.

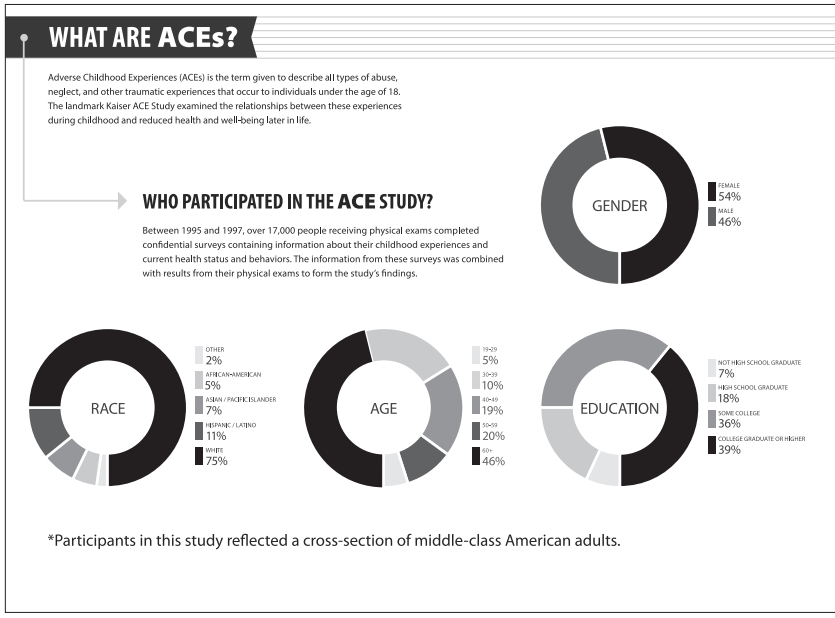
A trauma survivor, especially those whose traumas date from childhood, may not be able to remember what actually happened to them because the painful emotions they experienced at the time have been buried in the unconscious, a phenomenon known as repressed memory, or *repression*. These repressed memories can cause various mental disorders later in life that involve anxiety, depression, dissociation, or other syndromes. The recommended treatment for these mental disorders is some type of therapy. More broadly, any psychic damage done to the individual early in life can have serious, negative consequences over the long term.

After a traumatic experience, a person may reexperience the trauma mentally due to trigger reminders, or *triggers*. This phenomenon is also known as *re-traumatization*. The flashbacks, panic attacks, and nightmares that afflict combat veterans and other PTSD patients are the best-known examples of this tendency to relive or reexperience a traumatic event from the past.

ADVERSE CHILDHOOD EXPERIENCES

It is important to note that the definitions of *trauma*, and of the *adverse childhood experiences* that are its chief cause, have continued to broaden in recent years. A landmark study on ACEs conducted by Kaiser-Permanente from 1995 to 1997 studied over 17,000 patients receiving health care from the organization. The results of the data collected indicated that nearly two-thirds of study participants reported at least one ACE, and more than one in five reported three or more ACEs. Surprisingly, a majority of this population was white and middle-class. The Centers for Disease Control and Prevention (CDC) website offers much information on adverse childhood experiences, including findings from this study (www.cdc.gov/violenceprevention/childabuseandneglect/acestudy). Figure 1.1 is derived from an infographic on the CDC website and shows demographic information from the ACE study.

Given our cultural biases, researchers and laypersons assume and expect ACEs in communities of color and poor populations. Since the ACE study's data disproved our ideas about trauma's prevalence within the underclass, policymakers ignored its findings for many years because of what it revealed about American families and the universality of childhood experiences. The



Source: CDC, https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html

FIGURE 1.1
What Are ACEs?

results hit too close to home; the truth is that nearly everyone experiences adverse childhood trauma. It crosses socioeconomic classes, ethnicities, race, religious beliefs, geographical regions, and all the other demographic markers.

Categorized by incidents of abuse, neglect, and family dysfunction, ACEs include situations or events happening prior to the person's eighteenth birthday that extend beyond the normal challenges of growing to adulthood that everyone experiences. The period of time between childhood and adulthood has lengthened over the years, in part due to elementary and secondary education requirements, as well as child labor laws and changes to American parenting philosophies that infantilize people well into their third decade. The lengthening life span of Americans has also expanded the time given to children, adolescents, and young adults to navigate developmental tasks as they try on different identities. This is a typical part of exploring careers and lifestyles before settling into long-term goals for adulthood.

The developing brain is affected by chronic, or toxic, stress. The brain's response to stressful events heightens, and when its stress response is on constant high alert, this results in long-term inflammation and disease, but more importantly, it leaves the adult with a high ACEs score, which makes them more likely to overreact to everyday stressors like heavy traffic, waiting in long queues, or not finding a parking space at work; occasions that many adults easily navigate. When a person's baseline is this high, the smallest incident

may trigger a negative feedback loop from which escape is difficult without deep reflection and the use of healing modalities. Chronic stress also ages the child on a cellular level, eroding their telomeres as well, thus setting them up for early debilitating disease. The more the brain is stressed in childhood, the more the hippocampus shrinks. The hippocampus is responsible for processing emotion and memory and managing stress. Between the brain's high stress setting and the hippocampus's dwindling size, it's easy to understand how children feel chronic anxiety and its long-term physiological effects.

Children with high ACEs scores who lack loving adults in their lives transition into adolescence with poor decision-making skills and executive functions and are more likely to develop mood disorders that involve anxiety or depression. This pattern continues into adulthood, leaving adults with high ACE scores easily stressed and overreactive in most situations, unless they've encountered and incorporated coping skills like therapy, meditation, mindfulness, yoga, immersion in nature, acupuncture, and other brain-body approaches.

When children experience one or more of ten types of traumatic incidents recognized by the ACEs study instrument, the resulting stress can impair their coping skills for the challenges of everyday life, and can even increase their risk factors for chronic, debilitating disease. The most commonly occurring of these ten types of experiences are child abuse, household challenges (chiefly domestic violence), and child neglect. Within these categories, childhood experiences are divided further.

ABUSE

Abuse includes emotional, physical, and sexual abuse. Emotional abuse may involve an attempt to control another person, and often the adult is unaware that their behavior is abusive, as they've adopted their parenting or relational techniques from their own dysfunctional parents or family. The behavior includes accusations, blaming, and monitoring of the child's activities and behaviors. Emotionally abusive parents constantly criticize their child's talking, dressing, communications with others, and coping mechanisms, using this criticism as a form of control. These parents use sarcasm, name-calling, and verbal assaults to dominate children. Emotionally abusive parents withhold affection as punishment, refuse to communicate with the child at all, and isolate the child from family and friends who support them. Finally, they refuse to acknowledge their part in the family dynamic and rarely take responsibility for their actions or apologize. Physical abuse happens when a parent or caregiver inflicts a physical injury on the child or adolescent's body. These injuries can be marks, cuts, bruises, welts, muscle sprains, broken or burnt skin, broken bones, and other bodily indicators.

The survivors of child abuse don't trust authority figures, for many reasons. Even though they may not recognize parental negligence or abuse,

experiencing it affects a child's ability to trust anyone. They have learned that authority is punitive and takes things away. "Authority figures" in the form of law enforcement officers and social workers acting on behalf of the state remove children from their parents when there's an altercation or a report of abuse or neglect. The bank or creditors take belongings away from homes when parents default on loans, thus leaving their parents afraid, anxious, and angry. Trauma survivors have zero positive interactions with authority. The model they have observed vis-à-vis their parent's interactions has left them with the belief that authority takes and punishes, but never gives or soothes.

The survivors of child abuse sometimes become aggressive or display other behavioral problems. Usually they suffer high anxiety and are always on the alert, reading the signs for when the parent or caregiver is likely to strike out at them again. Abused children often suffer post-traumatic stress disorder (PTSD) and allied emotional reactions. Children growing up in physically abusive environments become hypervigilant to anger so that they can quickly identify and absent themselves from the violent parent.

Children who are sexually abused experience unwanted sexual activity with adults or older children who use force, make threats, and otherwise take advantage of them. Some child sexual trauma survivors experience disassociation, which deals with memory. The memory of the abuse is not lost, but its recovery is impossible or spotty. Thus, children, adolescents, and adults with these experiences exhibit memory disturbances, which may affect them in many situations, including studying, reading, knowledge-building, and information-seeking. The survivors of child abuse also experience low self-esteem. Children who survive emotional, physical, or sexual abuse internalize their injuries and deploy self-criticism because they believe that something is inherently wrong with them and they asked for or deserved the abuse. People may believe that physical abuse is worse than emotional abuse, but the brain regions relaying information about emotional pain and physical pain are the same; emotional abuse is experienced at the same level as physical pain by our nervous system.

HOUSEHOLD CHALLENGES

Household challenges include situations in which the child's mother was treated violently, or in which any of the following occurred in the family: substance abuse, mental illness, separation and/or divorce, or incarceration of a household member. Domestic violence, or intimate partner violence (IPV), reflects destructive patterns of behaviors in which one partner maintains power and control over another. This dynamic involves physical or sexual violence, threats and intimidation, emotional abuse, and economic dispossession. Children easily become pawns in the IPV pattern. Figure 1.2 shows how at the center of physical and sexual violence in a household there is a

need for power and control. Power when used and manipulated in this fashion affects children's self-esteem and can cause anxiety, depression, and, in extreme cases, PTSD. Children believe that what they experience within the family is normal. Without exposure to healthy family models, children who are manipulated and coerced may likely continue these patterns in their intimate relationships and families when they become adults.

Tobacco, alcohol, and both prescription and illegal drugs are substances that parents and caregivers abuse within a family setting. Prenatal exposure to these substances can greatly affect children and is associated with miscarriage, stillbirth, and sudden infant death syndrome. Exposure may cause low birth weight and physical deformities, cognitive impairment, conduct disorders, depression, or mental retardation. Furthermore, substance abuse within the family can lead to IPV, divorce, exposure to crime, and poverty. Children's experience of substance abuse within their family may predispose them to abuse substances as adolescents and adults.

Source: Domestic Abuse Intervention Programs (www.theduluthmodel.org)

FIGURE 1.2
Power and Control Wheel

Likewise, when a parent or caregiver experiences mental illness, it affects children and their development. A parent with untreated bipolar disorder cannot recognize how their disease affects their children as it seeps into their behavior and takes root in their psychology. Mental illness can affect a person's ability to parent and may create impaired parenting and family discord. Untreated mental illness is strongly associated with general family dissonance, marital problems, and a chaotic home environment, all of which can damage childhood emotional development. Children thrive in safe, stable environments and rely, for the most part, on the parent behaving dependably and creating an atmosphere of calm and security. According to the National Alliance on Mental Illness, one in five adults (43.8 million, or 18.5 percent) in the United States experiences mental illness each year. Their data reveals that 1.1 percent of adults live with schizophrenia, 2.6 percent live with bipolar disorder, 4 percent have experienced PTSD, 6.9 percent have had a major depressive episode, and 18.1 percent have experienced any of various anxiety disorders.

Researchers identify the aforementioned mental illnesses as *serious mental illnesses* (SMI). Children with SMI parents have a child psychiatric diagnosis of 30 to 50 percent. Children growing up in homes affected by mental illness feel lonely, vulnerable, helpless, and invisible. They experience their family environment as terrifying and impossible to adjust to. Information about their parents' mental illness may be withheld or considered shameful, which fuels their stress and anxiety. Children with mentally ill parents sometimes become the caregiver, are "parentified," and are robbed of the carefree atmosphere that childhood should provide within families. Moreover, when all of the family's focus and resources are spent on the mentally ill adult, the children's needs can be overlooked or dismissed. Untreated mental illness affects children in that they display impaired social functioning, exhibit poor academic performance, experience mood disturbances, and have poor emotional regulation. They experience anger, anxiety, and guilt while also feeling socially isolated due to shame and stigma. Their risk of drug use and poor social relationships increases.

Dissolution of the family unit due to parental separation, estrangement, or divorce can have long-term effects on children's psychology and make it more difficult for them to form healthy attachments in adulthood. These events also tend to introduce great financial change in children's lives. Generally a divorce increases a child's dependence on their parents and other family members and caregivers, but it works in the opposite way with adolescents: it accelerates their independence. Learning to transition between one or more households with different values, beliefs, and rules presents challenges, but on the upside, this increases the child's adaptability to varied environments. Short-term reactions include considerable anxiety, as the child's world is destroyed and rebuilt in a fashion that they have no control over. Worrying about where parents are going, when the child will see them again, and greater existential questions such as "If my parents don't love each other anymore,

does this mean they won't love me someday?" generates constant stress and anxiety. Small children may regress into seeking more attention from parents, bedwetting, or returning to negative behaviors. Adolescents can become angry, defiant, and rebel against parental authority.

Child risk factors for parental incarceration include child criminal involvement, physical problems and antisocial behavior, poor educational attainment, impaired economic well-being, and diminished parent-child attachment and contact while the parent is incarcerated. As the majority of incarcerated Americans are men, most research on the childhood effects of this life experience deal with the imprisonment of fathers, stepfathers, grandfathers, uncles, and male cousins. However, maternal incarceration has grown rapidly in recent years, and the number of children with a mother in prison increased 131 percent from 1991 to 2007, according to Glaze and Maruschak (2008). As the world's leader in incarceration, the United States saw a dramatic growth of 500 percent in the size of the prison population over the last forty years.

The U.S. criminal justice system is plagued by racial disparities and drug sentencing disparities. Almost 60 percent of the people in prison are people of color. Black and Hispanic men, who comprise a small percentage of the national population, are incarcerated at higher rates than white men. Incarceration poses difficulties for maintaining intimate and family relationships. Families find that making regular visits, phone calls, and sending letters and packages to their loved ones in prison can be difficult and costly. The financial burdens created by the incarcerated parent's inability to contribute to the family's budget exacerbate this situation. Families suffer economic insecurity and may deal with the hardship by using public assistance. Families feel emotional strain because they cannot connect with their incarcerated member's daily life and experiences. Maternal stress may affect a mother's ability to offer secure parent-child relationships.

Most mothers and fathers self-report that their children perform worse and experience learning difficulties after their father's incarceration. Foster and Hagan's research (2015) corroborates this anecdotal data. They discovered that parental incarceration decreases the educational attainment of children and contributes to their long-term social exclusion. Murray, Farrington, and Sekol (2012) suggest that the children of incarcerated parents experienced turmoil and upset prior to the parents' imprisonment, thus they are at risk for a variety of adverse behavioral outcomes. Also, they suggested that studies show parental incarceration is associated with a higher risk of children's antisocial behavior, but not for mental health problems, drug use, or poor educational performance. Gottlieb's research (2016) suggests that children who experience household incarceration in early adolescence are at greater risk of having a premarital first birth, particularly when the father or an extended family member is incarcerated. Nonmarital childbearing, particularly coupled with growing up in a single-parent household, suggests that children have low educational attainment, low economic security, and decreased physical

and psychological well-being. Children with incarcerated parents experience a unique anxiety related to the cycles of jail time. Uncertainty about their parent's absence and return can potentially cause more stress than if the parent was serving a long-term prison sentence.

Wildeman (2013) researched the consequences of mass imprisonment on childhood inequality and found that the U.S. prison boom was a key driver of the growing racial disparities in child homelessness, thus increasing black-white inequality in this risk by 65 percent since the 1970s. Finally, gender plays a role in how a child feels the effects of parental incarceration. Girls and boys are socialized to process experiences in different ways. Girls internalize, while boys externalize. Externalizing includes aggression and acting out. Internalizing means that the child's feelings are displayed via sadness, sympathy, and anxiety. Brewer-Smith, Pohlig, and Bucurescu (2016) collated data from adult female prison inmates who had incarcerated parents during childhood. Their regression analyses of data revealed that for women, having incarcerated adult family members was related to greater frequency and severity of childhood abuse and a higher incidence of neurological deficits in adulthood, especially related to traumatic brain injuries, compared to those without incarcerated adult family members.

NEGLECT

Child neglect, both emotional and physical, comprises the majority of maltreatment reported to child protective services. The majority of American children enter the foster care system due to neglect. Homelessness and household insecurity are components of neglect. Having an incarcerated parent increases the likelihood of children entering foster care. In its most severe forms, emotional neglect can cause major physical and cognitive developmental delays. Its effect on the brain is irreversible. The prefrontal cortex fails to mature, which reduces the child's capacity for executive functioning—focus, sustained attention, decision-making, and problem-solving.

Neglectful parenting is also associated with mental illness and addiction. Poverty and social isolation are also associated with neglect. Emotional neglect occurs when parents fail to respond to a child's emotional needs. Parents' failure to validate their child's feelings results in the child feeling deeply alone and isolated. The children believe that the emotional neglect is their fault, they caused it, because they are too needy, too sensitive, or selfish. Neglect also involves parents not meeting their children's emotional needs. If a child asks for help, they are rebuffed and chided for being too sensitive or needy. Once conditioned to being shut down, emotionally neglected children never ask for help from a parent, caregiver, or anyone else because they have been taught that their needs are inconsequential. The types of parents who tend to emotionally neglect their children are authoritarian, narcissistic, perfectionist, or

absent. They shame and humiliate their children. The emotional neglect of children results in lack of confidence, difficulty dealing with criticism, panic, and profound loneliness. Since the children are trained to have no needs or voice any emotional needs, they shut down, become emotionally numb, and experience difficulties feeling, identifying, managing, and communicating their emotions because the parents disavowed their expression of emotions they felt discomfited by.

Sometimes emotionally neglected children turn toward perfectionism as a means of being self-sufficient, unburdensome, and difficult to criticize for their failings. They can become oversensitive to rejection by taking everything personally. They also lack clarity about boundaries and expectations. All of these experiences can increase the risk of anxiety and depression, and deficits in emotion perception and emotional regulation. The children may be desensitized, have less empathy, and respond poorly to the emotional expressions of friends and family members. Emotional neglect by a parent arrests brain development. It makes attaching to others and having lasting, healthy adult relationships difficult because trusting others is challenging. Emotionally neglected children can have difficulties recognizing the facial expressions of others that show different emotions, thus diminishing their capacity for empathy, understanding, and connections with others. All of these outcomes of neglect can affect academic performance and intelligence.

Physical neglect refers to whether the child's basic and age-appropriate needs for food, clothing, shelter, and medical care are met by the parents. Physically neglected children may not be enrolled in school, or the parents may not monitor the child's attendance. Children are left alone at home for lengthy periods of time that exceed what is recommended by the American Academy of Pediatrics. Identifying physically neglected children can be easy. They are inappropriately dressed for the weather, appear dirty, smell unwashed, appear malnourished, and may display skin rashes, skin disorders, or bites from bedbugs and other vermin. Their behavior includes meager social skills, food stealing and hoarding, disinterest in basic hygiene, and poor school performance and attendance—including falling asleep in class. The children may show a severe lack of attachment to parents or other adults, and yet they can also be clingy and demand excessive attention and affection. Like other forms of abuse and neglect, physical neglect affects the physical, psychological, cognitive, and behavioral development of children. Developmental delays are customary and expected. Lack of boundaries is common because abused children find the limits set by adults and caregivers to be unfamiliar. The physical consequences of neglect can range from minor cuts and bruises to brain damage and death. The psychological outcomes can range from chronic low self-esteem to severe dissociative states. The cognitive effects also range from attention disorders to neurocognitive disorders. Behaviorally, physically neglected children may experience alienation from their peers or may exhibit disturbingly violent actions. All of these difficulties affect individual children and society as a whole.

Trauma and abuse stunt neurological development, leaving many children, and adult learners, emotionally functioning at levels well below their chronological ages. Figure 1.3 summarizes the many forms that adverse childhood experiences can take. Grownups can help children process adverse experiences that trigger feelings of loss and unworthiness. Those who provide unconditional love lay a groundwork for children to gain the skills for greater resilience.

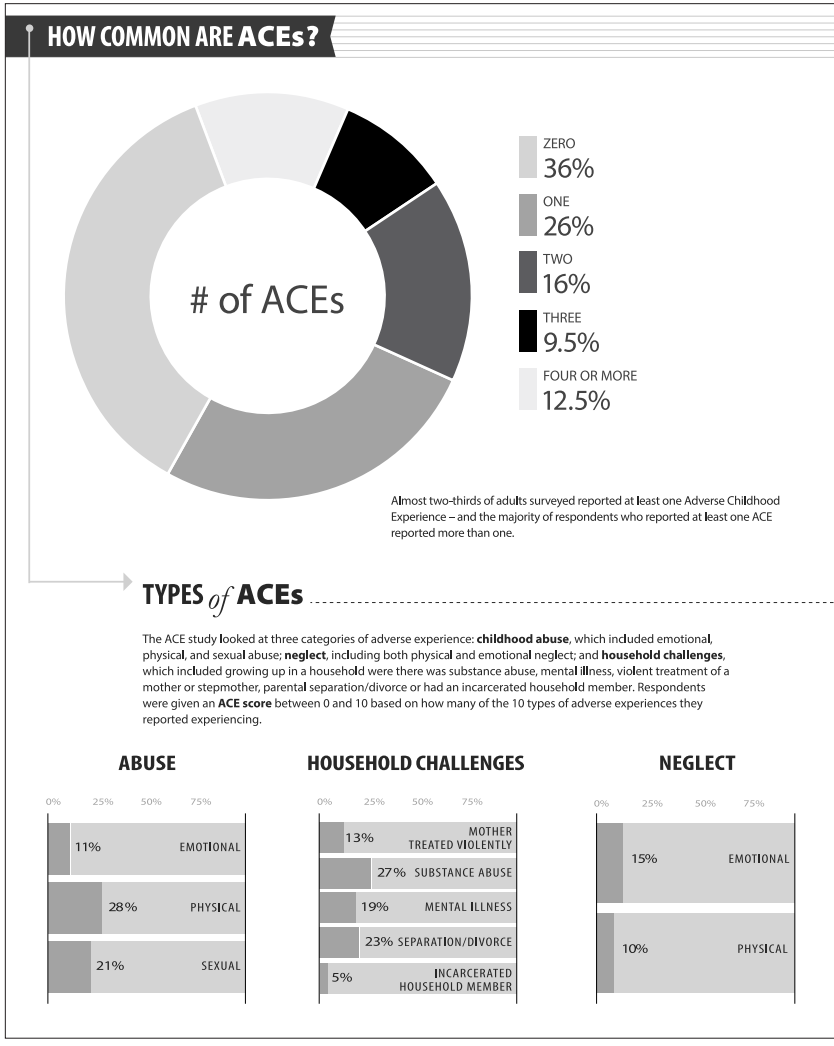


FIGURE 1.3
Types of ACEs

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