{TIMBO} Trauma-responsive Innovations for Mind and Body

FROM COMPASSION FATIGUE TO HEALING CENTERED ENGAGEMENT:

TRANSLATING TRAUMA-INFORMED VALUES INTO ACTION

Suzanne E. Jones

A PUBLICATION OF THE TIMBO COLLECTIVE

WHO WE ARE:

THE TIMBO (TRAUMA-RESPONSIVE INNOVATIONS FOR MIND AND BODY) COLLECTIVE IS A WOMAN-FOUNDED NONPROFIT THAT BUILDS COMMUNITY WELLBEING THROUGH PERSONAL AND RELATIONAL TRANSFORMATION.

SINCE 2012, TIMBO HAS EMPOWERED THOUSANDS OF WOMEN IN BOSTON, THE U.S., KENYA, IRAN, AND HAITI TO BREAK THROUGH PERSONAL TRAUMA AND MAKE AN IMPACT ON THE WORLD AROUND THEM.

THE TIMBO METHOD PROVIDES A SCIENCE-BASED, BODY-CENTERED FRAMEWORK FOR REVERSING LONG-TERM TRAUMATIC STRESS AND SUPPLANTING IT WITH A SENSE OF CONFIDENCE AND SELF-EFFICACY.

TIMBO FOCUSES ON HEALING VULNERABLE POPULATIONS OF WOMEN - AND THE SYSTEMS OF CARE WHO SERVE THEM - TO TRANSFORM THEIR LIVES AND BUILD MORE EMPATHETIC, IMPACTFUL COMMUNITIES.

©2018 COPYRIGHT BY TIMBO. ALL RIGHTS RESERVED.

THE TIMBO COLLECTIVE

trauma-responsive innovations for mind and body

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

INTRODUCTION 4

CHALLENGES OF TIC INTERVENTIONS............5

COMPASSION FATIGUE...............................7

MINDFULNESS-BASED PRACTICES:
BENEFITS AND LIMITATIONS.........................9

TIMBO: A NEW FRAMEWORK........................12

Healing the Roots of Trauma........................13

Social Restoration..15

Toward a Strengths-Based Approach...............16

CONCLUSION...19

REFERENCES...20

EXECUTIVE SUMMARY

Trauma-informed care (TIC) offers critical education for our healing professionals on the ways in which adverse events and experiences in childhood can affect their clients' health and well-being as adults.

Agencies, however, need to be more than trauma-informed to successfully address both the impact of trauma on their clients' well-being and the ways in which its damage is reinforced by burned out systems of care. A growing number of clinicians and caregivers experience burnout and compassion fatigue as they struggle to feel efficacious in their jobs (Evans et al., 2018; O'Conner et al., 2018; Hensel et al., 2015). Both our service organizations and their service users are in need of actionable tools and practices that transcend pathology, can be shared and strengthened through organic social networks, impact the root mechanisms of trauma, and increase overall well-being for all parties in the system (Leitch, 2017).

The TIMBo Method provides a cognitive-somatic, healing-centered solution that fosters healing and empowerment in the individuals and the relationships involved in caring for vulnerable populations. This approach views trauma as a collective experience and highlights the ways in which its healing must also be collective.

The term *healing-centered engagement (HCE)* offers a more holistic approach to fostering well-being through relationship, culture, and spirituality, and experienced through a trauma-informed lens. HCE interventions are strengths-based, involve a collective view of healing, and re-establish the central role of culture in well-being. TIMBo's natural and organic spread through social networks makes it an affordable, accessible and sustainable HCE intervention; one that fosters collective transformation to benefit all individuals in the system.

©2018 COPYRIGHT BY TIMBO

{TIMBO}

INTRODUCTION

This paper explores the connection between gaps in trauma-informed care and staff burnout. It also presents an innovative solution for decreasing staff compassion fatigue while simultaneously improving program efficacy, with the long-term objective of shifting a system's culture toward one of *healing-centered engagement* (Bokhour et al., 2018). Since the publication of The Adverse Childhood Experiences (ACE) Study in 1998, evidence continues to mount that traumatic events in childhood increase the risk of morbidity and mortality across the lifespan (Felitti et al., 1998). The findings of the ACE report have inspired a growing number of trauma-informed services and programs for vulnerable populations, as well as trauma-informed education for staff in health services. A trauma-informed care framework is intended to reduce the common pathologizing of symptomatic behavior by understanding it as a "normal reaction to abnormal experiences."

This framework has led to a fundamental paradigm shift in thinking from *"what is wrong with you"* to *"what happened to you?"* But gaps between education/training and direct service practice leave burned out providers at risk for personal health problems and the continued erosion of empathy (Weilenmann et al., 2018).

Because trauma is perceived, remembered, and lives in somatic and visceral body systems, the addition of body-based education and practices can fill current gaps in trauma-informed programming (Brom et. al., 2017) while helping reduce rates of burnout and compassion fatigue in staff, whose own ACEs continue to impact work associated well-being (Evans et al., 2017). The TIMBo method produces a two-directional flow of positive impacts and outcomes in and between staff and clients simultaneously, which is the essence of healing centered engagement.

©2018 COPYRIGHT BY TIMBO

CHALLENGES OF TRAUMA-INFORMED CARE INTERVENTIONS

To foster well-being, we must think beyond treatment of "identified patients" and recognize the roles that empathetic relationship, connection, and personal empowerment play in sustained healing and recovery. Successful incorporation of these elements through agencies and systems depends upon the well-being of the staff within the system. Agencies that hope to foster well-being for their service users must first focus on the holistic health of their staff. To do this, a solid recognition of ACEs in staff is necessary to address the gaps between trauma-informed education and direct care, the rise of compassion fatigue, and the pathway to holistic health for all.

Since the release of the ACE study, the idea of trauma-informed care has gained traction in schools and institutions across the U.S.; but the approach has been increasingly challenged as incomplete. With this recognition, recent trauma-informed approaches are evolving with the aim of creating a culture of healing-centered engagement via systemic relationships that promote recovery and prevent re-traumatization—a challenging task, given the natural hierarchical power dynamic (and resulting feelings of disempowerment in both staff and client) that characterizes the traditional care environment (Holmes et al., 2004; Lawn et al., 2015). Overworked staff, inefficient communication, and feelings of devaluation have a negative impact on client care and point to the need to prioritize practices that move beyond unidirectional trauma-informed care (from staff to client). Service providers need to feel a sense of achievement in their jobs, in association with feeling valued and supported by their superiors, in order to deliver impactful treatments. Healing-centered approaches, when diffused through all systemic relationships, can meet these needs.

Through trauma-informed education, service providers have gained a solid understanding of how ACEs negatively impact their service users neurologically, emotionally, and behaviorally. This has led to a single-point focus on adversity in patients and on the individual's experience of harm, injury, or trauma ("what happened to you?") (Sweeney et. al., 2018).

> "Current trauma-informed care provides little insight into the root cause of trauma in neighborhoods, families, and schools and instead runs the risk of focusing on the treatment of pathology rather than fostering the possibility of well-being."
>
> –Shawn Ginwright, author of *Hope and Healing in Urban Education: How Activists and Teachers are Reclaiming Matters of the Heart*

This focus only on patient and only on victimhood contributes to increased burnout in staff, who also have a history of ACEs, and often experience feelings of responsibility and overwhelm without understanding the link between their own ACEs and the responses they have during work with clients (Evans et al., 2018).

©2018 COPYRIGHT BY TIMBO

{TIMBO}

CHALLENGES OF TIC, cont.

To pave the way for a truly strengths-based approach to full healing and recovery for both service users and burned out staff, we must educate them on (1) the central role of primal body responses to trauma (past and present), and (2) the early development of adaptive thoughts and behaviors in response to traumatic experience.

The fact that, as human beings, most staff have a history of unresolved ACEs is a reality that is largely unrecognized and unaddressed by both the staff themselves and the systems within which they work. Unrecognized ACEs in staff contribute to an increase in stress reactivity, an erosion of empathy, and an overall reduction in staff well-being, inhibiting the positive shift in systemic relationships that agencies seek. The role of somatic/visceral memory and implicit memory (remembered or not)—both in service users *and* staff members—as the root mechanism in traumatic experience continues to be misunderstood or marginalized in many helping organizations. In seeking to create a culture of healing-centered engagement through systemic relationships that promote recovery and prevent re-traumatization, these mechanisms must be taken into consideration, and the negative effects of body-based traumatic memory must be understood and addressed.

Agencies that offer appropriate staff education and training and prioritize an *experiential* understanding of what tools and practices work directly with primitive body responses can leverage staff awareness and use of these practices to impact client care (Geller et. al., 2014). Staff at all levels of the system can create positive change in their work with colleagues and clients, and drive more impactful programming for service users.

There is little argument that the risk for traumatic stress begins in childhood and most often occurs in relationship with others, especially others upon whom the child is dependent for survival. But it is unreasonable to look only to clients as having adverse experiences in childhood. If we are to arm clinicians with accessible, effective tools and practices that truly put healing into the hands of survivors, we must first help our *providers* to apply these tools and practices for their own well-being. By not prioritizing this, burned out staff continue struggling with the exponential impact of their unresolved ACEs, often presented as feelings of guilt, inadequacy, and helplessness. This experience can replicate the original insecure attachment and/or relational traumatic experience for both staff and client, render trauma-informed care ineffective, and delay or prevent permanent healing. To pave the way for a truly strengths-based approach to well-being for both service users and burned out staff, we must first educate staff on: (1) the central role of primal body responses to trauma (past and present); (2) the early development of adaptive thoughts and behaviors in response to traumatic experience, and; (3) tools that directly interface with the

©2018 COPYRIGHT BY TIMBO

{TIMBo}

above mechanisms and shift internal states from stress-reactive to compassionately responsive. In so doing, staff can reduce their compassion fatigue through recognizing when implicit memories from their own past are sabotaging their ability to foster empathetic and healing relationships.

COMPASSION FATIGUE

The term *compassion fatigue* was first used in 1992 in the context of healthcare to explain the "loss of the ability to nurture." Later it was adopted by Charles Figley, who used it to describe the "cost of caring" in psychotherapists working with traumatized clients. Figley uses the term synonymously with secondary traumatic stress defined as "the formal caregiver's reduced capacity or interest in being empathic or bearing the suffering of clients and...the behavioral and emotional state that results from knowing about a traumatizing event experienced by another person." It is widely understood that empathy is the essential ingredient in an effective therapeutic relationship, with a broad definition of empathy as the ability to notice pain in others. According to Figley, empathy involves therapists "projecting themselves into the perspective of the client and experiencing the same trauma-related pain and emotions that the client is experiencing." He proposes that it is the emotional energy resulting from this empathetic response that vicariously causes the compassion fatigue (Sinclair et al., 2017).

Studies show that having a personal trauma is a contributing factor for secondary traumatic stress in clinical therapists. Among the studies we reviewed, the highest percentage of staff developing secondary traumatic stress were survivors of sexual assault, survivors of domestic abuse, and childhood trauma.

"Adverse childhood experiences are surprisingly common, although typically concealed and unrecognized. This suggests that most individuals have experienced adverse childhood experiences, may not recognize the experience, likely don't connect their early experience with issues in adulthood, and probably won't seek treatment for better health." (Felitti et. al., 1998)

Compassion fatigue is not caused by working with traumatized clients; rather, it is the perpetuation of the service worker's own biological stress responses that also have their origins in early childhood that underlie the development of compassion fatigue. When staff ACEs have not been acknowledged or addressed, they compound (cumulatively) through the experiences of feeling overwhelmed, ineffective, and powerless at work. These are the very conditions that likely replicate the original experiences that inform current symptoms, and are the very same mechanisms underpinning the symptoms of their clients.

©2018 COPYRIGHT BY TIMBO

{TIMBo}

COMPASSION FATIGUE, cont.

Compassion is a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action.

Often, a personal trauma history is a motivating factor in choosing to enter a helping profession, usually to serve those who have survived the same type of trauma. Given this understanding, compounded by higher rates of sexual trauma and domestic violence among females, we can understand why female staff experience higher rates of secondary traumatic stress (Hensel et al., 2015). An additional contributing factor may be that over 80% of the emotional (relational) labor in the workplace is taken on by female staff (Meier et al., 2006). In an environment where empathetic and compassionate relationships are critical to the health and healing of service users, caregivers are likely re-experiencing their own implicit trauma memories within the context of empathetic relationships. The relational labor in managerial or collegiate interactions may also unconsciously activate implicit trauma memories.

Like clients, staff need non-pathologizing ways to recognize and reverse the symptoms of their own ACEs. The health, wellbeing, and job perspective of staff directly affects client care and outcomes (Mohammadreza et al., 2011; Chin-Po et al., 2014).

When they do, staff naturally use their understanding of implicit trauma responses both with service users and in their relationships with colleagues—thereby becoming a driving mechanism of change through relational networks of the system. The universal triggers of stress, defined by Dr. Gabor Mate as uncertainty, lack of control, and lack of information (2004) are reinforced by the consistent feelings of confusion, powerlessness, and helplessness that professionals so often experience when dealing with trauma-affected populations, even with the knowledge of *what happened to them.* With training, staff can recognize the undercurrent of visceral responses beneath their reactions to the universal stress triggers during interactions with colleagues and service users. They can then use practices such as mindfulness to *change their relationship* to stress triggers; and they can share these practices in real time with others around them, reducing their compassion fatigue-related symptoms. The capacity to redefine one's responses to stress in this way results in a new relationship with self and others.

Pilot TIMBo data reveals that in female staff, burnout often presents itself as feelings of guilt or disproportionate responsibility. This contributes to difficulties in "leaving work at work," consistent feelings of carrying a heavy burden, and ultimately feeling ineffective in their jobs.

©2018 COPYRIGHT BY TIMBO

{TIMBo}

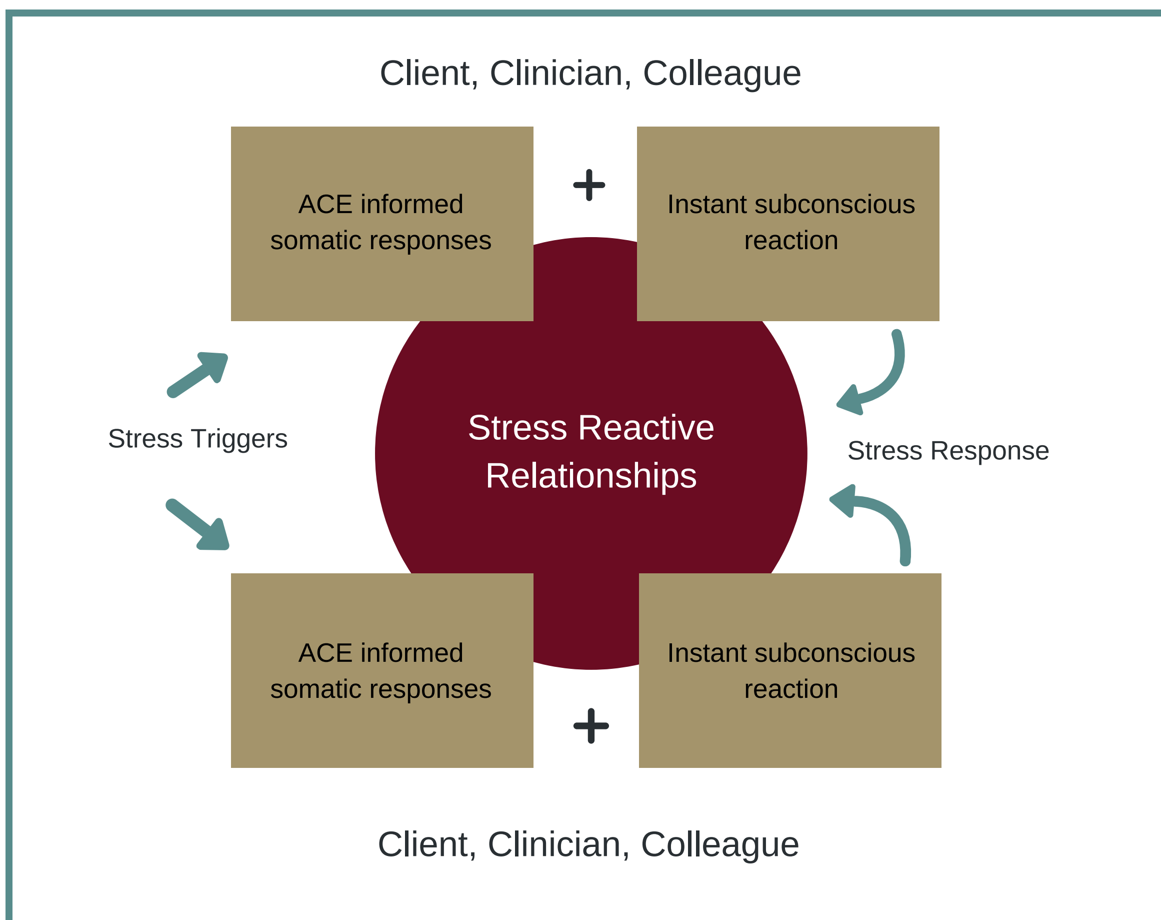
COMPASSION FATIGUE, cont.

A further challenge for trauma-informed care organizations and providers is the recent evidence that trauma can be passed down through three generations, creating stress-reactive behaviors in an individual with no capacity to relate it to a cognitive memory. The way this manifests varies from person to person, but in general it will possess a quality of negativity, catastrophizing, or complaining and blaming. Staff with intergenerational trauma may be habitually stress-reactive, anxious, or depressed and have no knowledge of the fact that they may have inherited the neurological blueprint of their parents, grandparents, or great grandparents (Enlow et al., 2013) (Fig. 1).

Conversely, individuals with measured risk tolerance see these same situations as opportunities and can respond with empathy, collaboration, and creativity.to help staff non-judgmentally notice and regulate their own visceral responses to day-to-day professional stress triggers. Some studies have shown that palliative care workers with a prevalence of PTSD who successfully engaged in mindfulness programs reported significantly less anxiety and depression (Chiappetta et al., 2018). One such widely used program is Mindfulness Based Stress Reduction (MBSR), developed by Jon Kabat Zin. Mindfulness works to effect the neurobiological mechanism of stress through non-judgmental awareness of internal and external states, coupled with simple

STRESS REACTIVE RELATIONSHIPS IN ACTION

Fig. 1



©2018 COPYRIGHT BY TIMBO

{TIMBO}

MINDFULNESS-BASED PRACTICES: BENEFITS AND LIMITATIONS

In the last decade, mindfulness-based practices such as yoga and meditation have proven effective for stress reduction and improved self-regulation. Brain scans of participants in mindfulness programs have shown increases of grey matter in key areas (such as the insula and cingulate) necessary for emotion regulation, impulse control, and empathy. The insula in particular is said to be the "seat of consciousness" and the warehouse for recasting internal body states as social emotions (Craig, 2011; Paulus et al., 2013).

These practices are drawing the attention of many communities working with trauma-affected individuals. Mindfulness trainings and programs have been shown to reduce compassion fatigue by providing practices that relax the autonomic stress response. Studies have shown this to be effective in improving biological and physiological aspects of trauma-related medical illnesses, such as chronic and acute pain.

Mindfulness associated increases in staff self-compassion can lead to subsequent increases in compassion toward patients and clients (Patsiopoulos, 2011). But when programs for staff and patients are siloed, the culture of the system as a whole remains uncommunicative, especially in systems working with survivors of trauma.

To capitalize on this natural diffusion within social relationships, organizations need clear, accessible, and effective steps that integrate mindfulness practices with trauma-informed values. Unfortunately, limitations still exist in the actionable integration of this strategy.

Yoga and meditation are considered complementary modalities, implemented primarily as extra-programmatic activities outside the continuum of care.

Current trauma-informed care interventions lack the practical skills that promote an immediate capacity for self-regulation (Leitch, 2017). An opportunity to include these skills is created when staff engage in mindfulness practices for their own self-care and then share what they've learned and experienced with their service users and others with whom they are in relationship. These activities are often sparsely attended, and it remains the exception that such practices are woven into clinical treatment. Often they are led by contracted instructors, who are not a part of the day-to-day fabric of the organization and have little to no established relationship with client and patient populations.

©2018 COPYRIGHT BY TIMBO

{TIMBO}

MINDFULNESS, cont.

Mindfulness practices can have a potent impact on changing systemic relationships, but only when all levels of the system hierarchy invest in learning them. Without this commitment, executive and administrative leaders remain disconnected from the day-to-day work of managers, direct service providers, and service users. A change in the system must be supported in practice, not just in theory, from the top down.

It's time for systems of care and the leaders within those systems to move away from the prescriptive understanding of "what happened to" clients, patients, and staff, and toward a holistic understanding of:

- The neurobiological survival responses that inform emotional, cognitive, and behavioral change.
- How these adaptive responses are learned and implicitly remembered from the earliest moments of life.
- How these implicit memories connect directly to somatically triggered bodily sensations.
- The role of relationship, community, and society in either reinforcing or healing negative implicit body memory.
- Implications for an embodied understanding of the above in both staff and system culture.

When staff personally understand the benefit of mindfulness practices in the context of relationship, tools for immediate self-regulation become a foundational element of all their relationships, whether manager:staff, staff:staff, staff:client, or client:client.

As such practices can have an immediate positive impact on the down-regulation of sympathetic responses, survivors of trauma (both staff and client) feel empowered with a simple and effective tool they can access and use anytime, anywhere. Service users are profoundly influenced by the shared sense of empathy and inclusion that these tools enable, and service agencies can directly benefit from the shift in culture that such practices foster, moving beyond fragmented ad hoc treatments toward empathetic, compassionate, embodied, and empowered communities of healing.

Mindfulness practices and tools offer an effective solution for immediate self-regulation, but they must be simple, accessible, and integrated into the moment-to-moment relational culture of the system, becoming a regular personal practice of staff and clients alike, at any given time.

©2018 COPYRIGHT BY TIMBO

{TIMBo}

TIMBO: A NEW FRAMEWORK

The TIMBo Method for healing trauma and building empathetic and emotionally resilient systems of care creates a culture of healing-centered engagement by directly addressing both the gap in trauma-informed education and the rising problem of staff burnout. The TIMBo Method is a low-cost, bottom-up innovation that scales organically by diffusing through existing social networks. Key to the success of the TIMBo Method is the positive change it fosters in an individual's relationship to themselves, and as a result, to others. This is accomplished by combining critical cognitive reframe, somatic down-regulation practices, and restorative relational experience.

To date there is little recognition that the developmental survival strategies adopted by children (largely unconsciously) are in themselves *strengths-based.* By identifying such neurobiological responses to adverse events as toxic stress, we miss the point and risk framing the ways in which children are wired to survive as negative (Leitch, 2017).

Rather, these autonomic-turned-cognitive/behavioral survival strategies are incredibly adaptive, but grew maladaptive over time. With this understanding, we can help survivors of ACEs see themselves as intelligent, adaptive human organisms that have unconsciously held tight to early neural circuits that are no longer needed. Further survival strategies develop as the brain of the child evolves through emotional and cognitive functioning, yet all subsequent thoughts, actions, and behaviors remain informed by the primitive response: *physical sensations in the body.* It is the fear of and resistance to these body sensations over a lifetime that reinforce self-sabotaging thoughts and behaviors, continue the cycle of stress in the body, and contribute to pathologies later in life. A child's deep need for connection underpins these survival responses, and as emotional and cognitive capacities develop, a shift in self-concept, largely stemming from the rejection of self, takes root and becomes the foundation for the perpetuation of toxic stress (Manyema et al., 2018).

In directly applying their understanding of this developmental process, human services staff can prioritize the positive intention of a child's natural survival adaptations, highlight it during treatment of the adult, and help survivors understand how these adaptations made sense in their bodies at the time. This reinforces internal strengths and competencies, and replaces "what happened to you" with "look how brilliantly you adapted to survive." *This shift in perspective is more accessible to staff when they gain insight into their own embodied survival strategies.* Self-compassion increases as a result, allowing for empathetic relationships that in time become woven through the fabric of the system (Hernandez-Wolfe, 2018) (Fig. 2).

©2018 COPYRIGHT BY TIMBO

{TIMBo}

Healing the Roots of Trauma

TIMBo is founded upon the premise that every individual has a series of early experiences that inform the manner in which their body, emotions, thoughts, and behavior (in that order) respond to external and internal triggers (Epstein, 2014 Rothschild, 2000). In the parlance of the 1998 ACE study, this learned response moves individuals from having "normal responses to abnormal experiences" in childhood, toward having "*abnormal* responses to *normal* experiences" in adulthood (Mate, 2004). TIMBo emphasizes the non-judgmental noticing of all body sensations, and TIMBo theoretical frameworks help individuals use compassionate, strengths-based language to directly communicate with their own body sensations. Originally designed as a group program for female trauma survivors, the TIMBo basic curriculum provides a progressive framework for exploring how emotions build up in the body and teaches simple, accessible, effective tools and skills for the practice of emotion regulation in response. Through repeated practice of these in-the-moment tools for self-regulation throughout the TIMBo sessions, out-of-date implicit stress responses are eventually replaced by new, implicit body responses.

"I wish everyone in here knew TIMBo. What a different world it would be." –Staff Manager

"I used to be weighed down by my job, now I love my work because I have tools in my toolbox for myself and my ladies." –Direct service staff member

EMPATHETIC RELATIONSHIPS IN ACTION

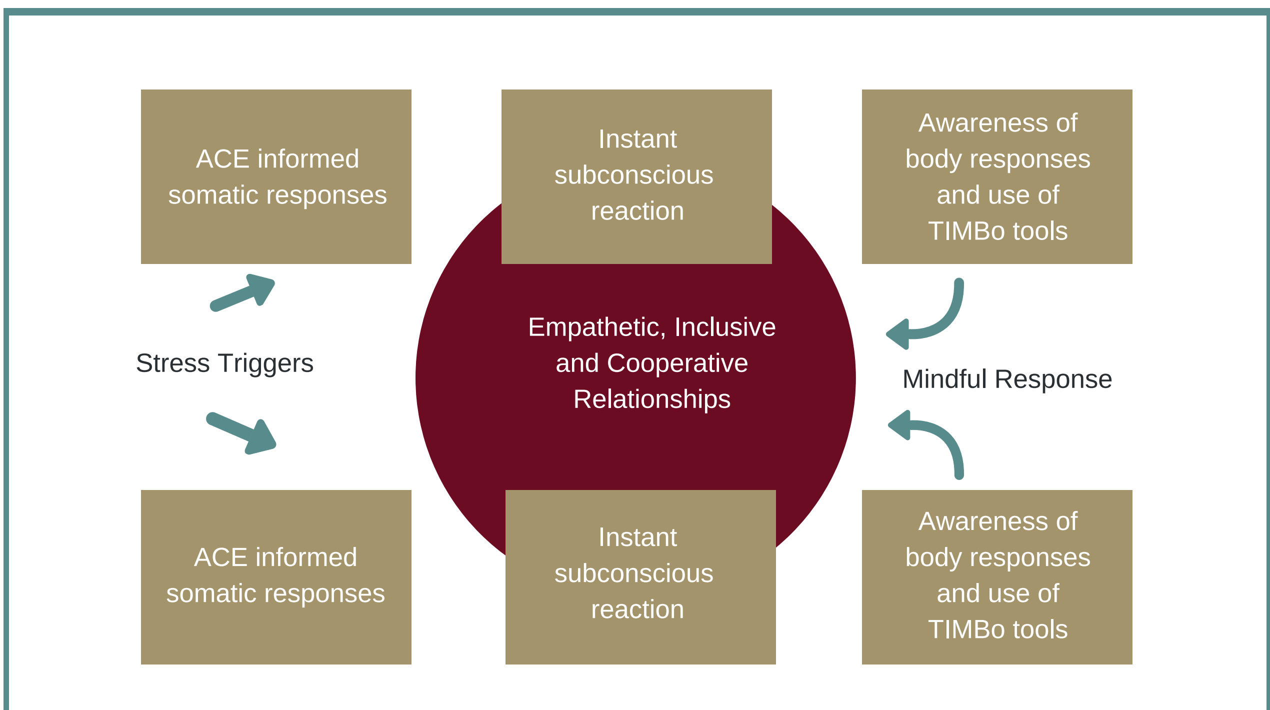


Fig. 2

©2018 COPYRIGHT BY TIMBO

{TIMBo}

Healing the Roots of Trauma, cont.

After eight years of implementing the TIMBo basic curriculum in a variety of practice environments, our experience and key findings have been further codified into a universal method of intra- and interpersonal interaction that fosters compassion and empathy, and builds resilience in both service users and the staff of organizations that serve them.

The TIMBo method is integrated into the care environment in a trauma-sensitive way; prioritizing attraction and choice over promotion and mandating. Because TIMBo interfaces with somatic stress responses universal to all individuals, staff benefit from being trained in its use through an embodied experience of the tools in their own lives. TIMBo integration is sensitive to the organization as an organism, which has also suffered some degree of social trauma. As such, the individuals working in it must be allowed to discover the positive impacts of TIMBo practices and trainings in their own life and work; this must be the result of their own choice to use TIMBo in their relationships. TIMBo trainings are not mandated, but they must be championed by an agency visionary with significant social influence within the system. Due to the hierarchy in staff structures, managers and supervisors who participate in TIMBo then represent a living example of the success of the tools for the team working under their guidance. Once an organization leader has adopted TIMBo practices in their life and work, the impact is immediately seen and felt, and clients and colleagues alike become attracted to the sense of safety their empathetic demeanor provides. This leads to a natural, culture-led diffusion of the innovation through the system.

©2018 COPYRIGHT BY TIMBO

{TIMBo}

Social Restoration

Trainings in the TIMBo method and TIMBo basic curriculum are unique in that they provide a social microcosm for participants, which allows for the renegotiation of trauma in a relational context. Clinical methods, complementary therapies, and mind/body practices are, for the most part, either experienced in a framework that replicates a power dynamic (therapist/teacher to client/student) or as primarily solitary practices such as daily meditation. To heal relational trauma, tools and practices for recovery must be practiced in the social context, and then immediately practiced in relationships outside the TIMBo group.

The TIMBo method, tools, theories, and practices are universal to all human beings, not just trauma survivors or just professional staff. TIMBo's capacity for social restoration makes it a powerful mechanism of change, particularly in contexts that involve a power dynamic, whether explicit or implicit.

Like dysfunctional families who expect children to change with no effort from parents to change their behavior, hierarchal systems cannot change by impacting only those without power. A shift in culture requires a commitment from those in power, allowing for staff leaders to foster well-being in all parties in the system through a shift in the power imbalance.

Through the experiential understanding of TIMBo in the context of their own lives, staff are able to both regulate stress responses that arise at work and maintain unconditional positive regard (Rogers, 2013) for both clients and colleagues. Staff use TIMBo tools in the moment for themselves (silently), while encouraging and reinforcing the use of TIMBo tools for colleagues and clients.

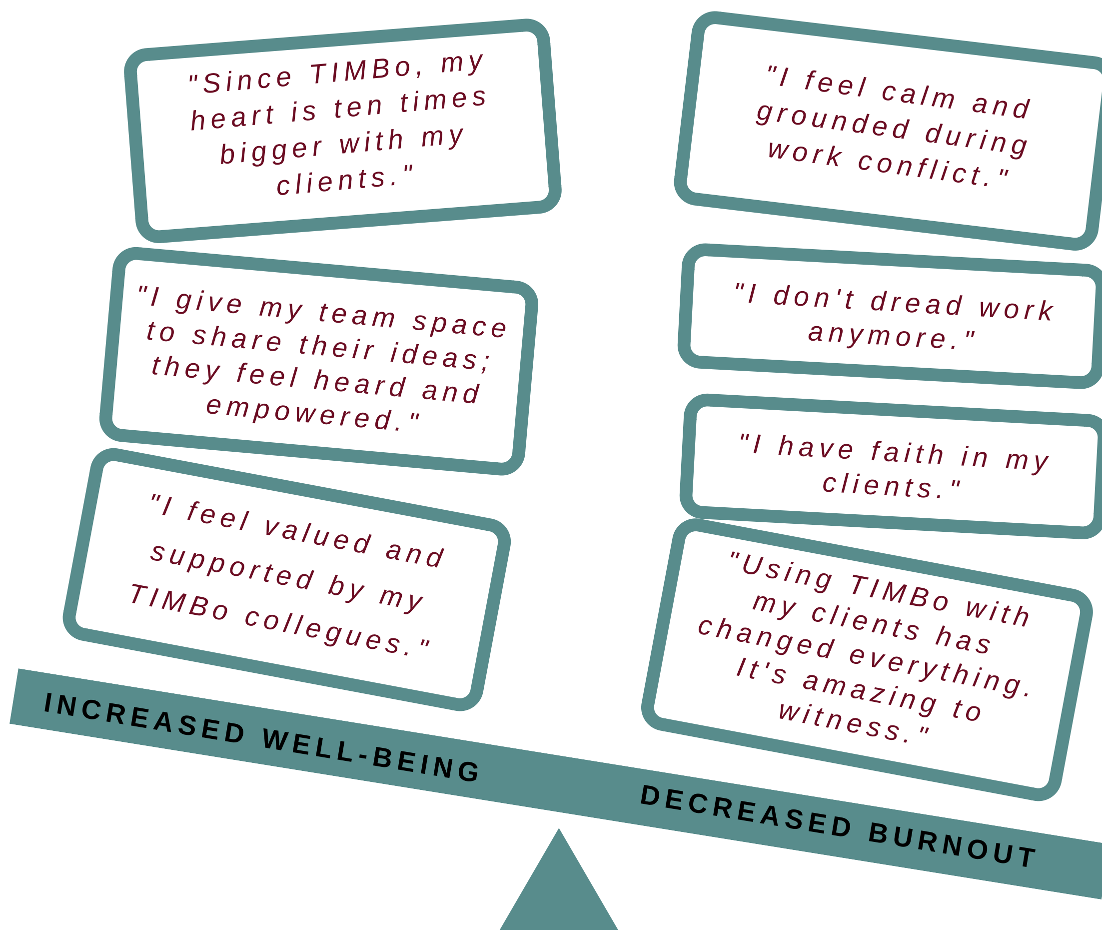
Drawing upon the pioneering work of Peter Levine (somatic experiencing) and Stephen Porges (polyvagal theory), TIMBo does not focus on trauma; the word trauma is not mentioned in the curriculum workbook, nor is it discussed in the group. Instead, practices focus on noticing visceral body sensations (or an absence of them) and understanding them as biological survival alarms that are established in the past. A simple sensation in the body informed by a past memory, repeated, often leads to health risk behaviors such as addiction, self-harm, eating disorders, and more. TIMBo participants are encouraged to become aware of distressing body sensations as they arise, and reframe them as opportunities to use TIMBo tools for self-regulation such as breathing exercises and compassionate self-talk.

©2018 COPYRIGHT BY TIMBO

{TIMBo}

Toward a Strengths-Based Approach: Empowering Staff to Heal Themselves

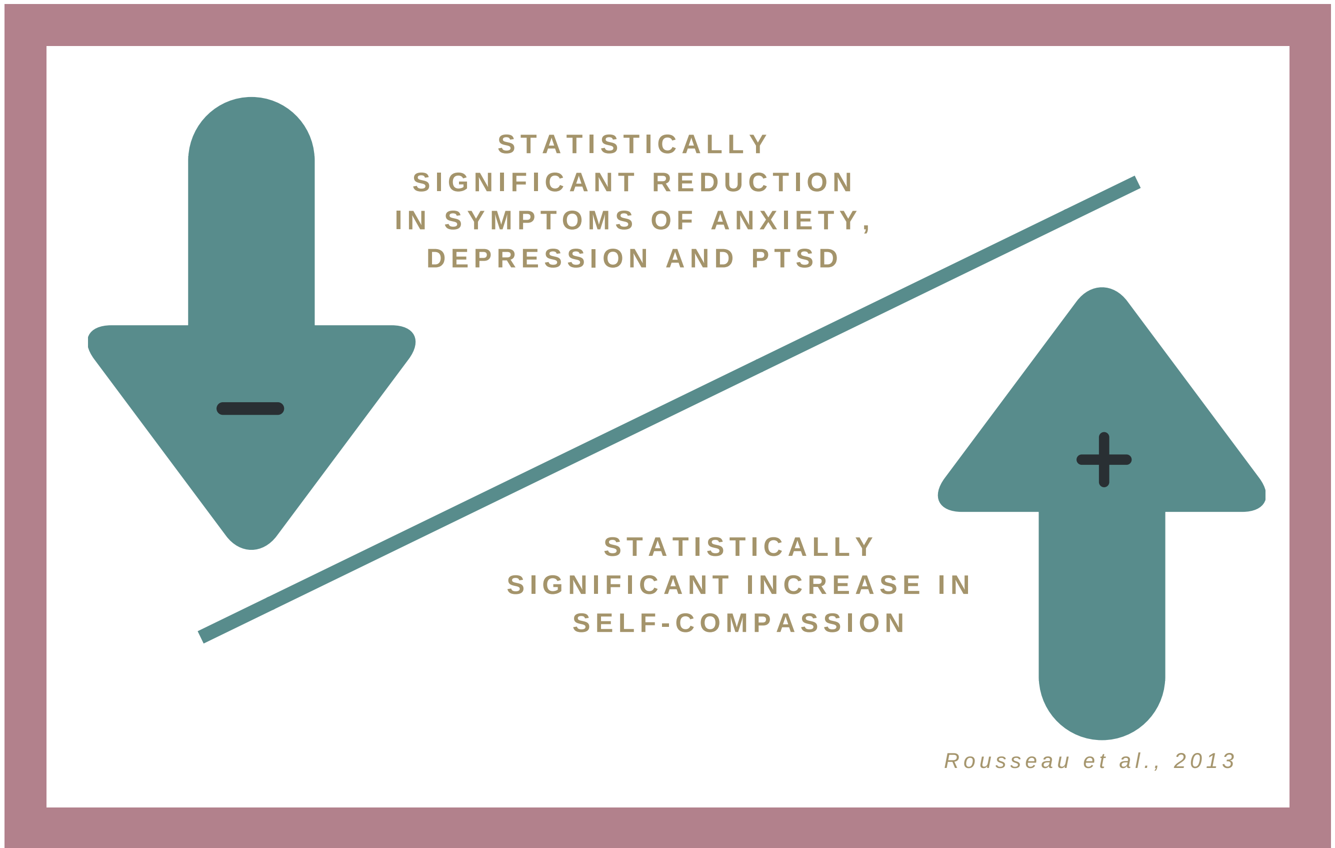
The root of compassion fatigue in health and human service agencies is the *resistance to feeling*. Without tools to non-judgmentally accept, understand, and create space around the emotions and sensations that arise at work (guilt, hopelessness, fear, resentment), resistance to these natural feelings is continually reinforced. The resistance to, or effort to shut off or escape from these visceral emotional experiences is what leads to compassion fatigue and the erosion of empathetic communication. Offering staff self-care practices like yoga and meditation outside the workplace is missing the target. TIMBo's unique strengths-based approach focuses on *changing one's perspective* to visceral experiences; and in doing so, it changes the quality of those experiences. This reframe places a sense of power and control back in the hands of the individual, while increasing confidence, resilience, and feelings of adequacy (which comes from sharing the new-found knowledge). Theories and practices for accepting visceral stress responses in a new and empowered way are critical for staff, because to have compassion is to *feel with*. To feel *with* an individual is to be fully present in body, mind, and spirit; to communicate resonance; and to express (often nonverbally) the sentiment, "I understand you because I understand me" (Geller et. al, 2104).

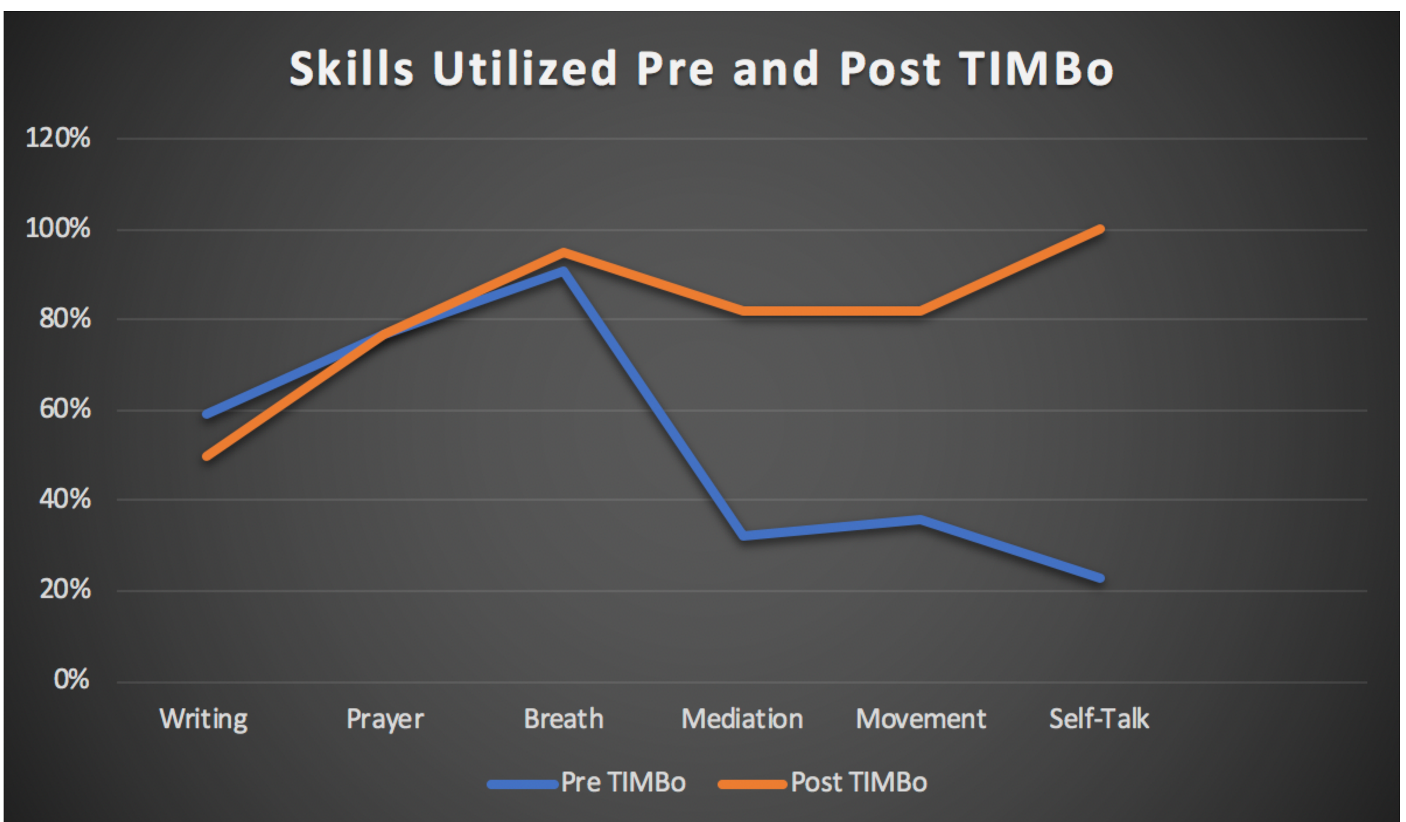


©2018 COPYRIGHT BY TIMBO

{TIMBo}

IMPACT OF TIMBO BASIC CURRICULUM





©2018 COPYRIGHT BY TIMBO

TIMBO FOR ORGANIZATIONAL WELL-BEING PILOT DATA

Qualitative pilot data of TIMBo staff training shows that **100% of staff in direct service roles** have experienced a decrease in burnout, while feeling an increase in job satisfaction and efficacy.

A recurring theme in participants interviewed (all female) is a newfound ability to recognize:

- Visceral sensations that accompany feelings of **disproportionate guilt and responsibility** (the need to fix).
- Early life survival rationale for this adaptive response to the suffering of others (feeling responsible/need to fix).
- Decrease in associated stress with the use of TIMBo tools and language.

Staff utilized tools for themselves and shifted how they interact with clients. Instead of feeling the pressure of trying to "fix" clients, **staff helped clients feel seen, heard and empowered.**

Staff express that clients are better served and feel immediately empowered when:

- Service providers explain biological survival responses in relation to body sensations to clients.
- Service providers explain these body responses as reacting to the past and not the present
- Service providers teach clients a simple tool such as breath for an **immediate shift in inner feeling states.**

©2018 COPYRIGHT BY TIMBO

TESTIMONY FROM THE FIELD

A Massachusetts residential substance abuse treatment program has been diffusing the TIMBo innovation through their agency for 18 months. Service users of the treatment center have been civilly committed, either by the courts or family members. Prior to the integration of TIMBo, the average rate of patient restraint, a disciplinary therapeutic measure that is often retraumatizing, was two to three episodes per month. Since their teams have been using TIMBo for themselves and with clients, the agency has seen a drastic reduction in the rates of restraint to just one restraint in a six month period. This may be attributed in part to the authentic sense of empathetic understanding created through TIMBo practices. The staff member who initiated this single restraint as the result of a vicious verbal attack, shared that TIMBo changed the way she experienced and engaged in the restraint incident, thus allowing for the restrained client to feel unconditionally loved and accepted once the incident was over. Most notably, the staff member described how she would have reacted prior to TIMBo:anger, resentment, holding a grudge, and feelings of “I don’t need this in my life.” She indicated that she most certainly would have left the area and not returned, avoiding interaction with the client for the duration of her stay at the treatment center. Through her TIMBo training, she self-identified this flight as a common survival response of her own. During the incident, she became aware of this stress/survival response in her body and calmly excused herself to the restroom to take ten to fifteen slow, deep breaths. During that brief moment she was able to track the down-regulation of her system and return to the scene with a new perspective. The staff member later connected with the restrained individual, expressing compassion and forgiveness, and noted the response of relief and surprise in the client, who had been bracing herself for rejection and judgment.

©2018 COPYRIGHT BY TIMBO

{TIMBo}

CONCLUSION

Some studies suggest that compassion fatigue can be alleviated by a sense of achievement, while others mention social support, reduced caseload, and more professional autonomy as important constructs to the mitigation of burnout (Sinclair et al., 2017)

Pilot results of TIMBo staff training are showing a sense of achievement in staff, a sense of community with fellow staff, and a sense of empowerment in work with clients. These outcomes are attributed to:

- An immediate and visible impact on work with clients.
- A newly created language/vocabulary among staff that creates a feeling of community and solidarity (i.e. “Can we do a TIMBo breath?” or “Let’s take a TIMBo walk.”
- Mind/body practices that can be deconstructed and offered in myriad ways to clients, based on the clinician’s instincts and training.

TIMBo training provides staff both a framework through which to compassionately understand their own stress responses, and accessible practices for in-the-moment regulation of those responses. Staff then translate this experience into real-time trauma-informed practices and actions for those with whom they work.

The practice of empathetic presence is critical for both staff and client (Geller et al., 2014), but unrecognized implicit body memories/sensations in staff can sabotage opportunities for empathetic presence that are so often available in care environments. TIMBo staff training empowers individuals to take an active part in the regulation of their own internal responses by compassionately understanding them at the source. Through this process, empathetic connection and understanding between all persons in a system of care is understood as the gift that it is—the gift of allowing a person to be fully seen, and of allowing staff to feel a sense of purpose in even the smallest moments. This sense of connection and purpose directly counteracts what we call compassion fatigue, creates a more empathetic culture of care, and can impact the intended outcomes of care organizations.

Through trauma-responsive training and education, systems of care that are focused on healing-centered engagement create a shift in their culture by taking steps to:

- Include simple practices for creating space (and down-regulating stress) in all organizational structures;
- Infuse trauma responsive practices through the network of all relationships in the system;
- Mitigate known stress triggers and change policies and practices to reflect such intentions.

©2018 COPYRIGHT BY TIMBO

{TIMBo}

REFERENCES

Bokhour, Barbara G., Gemmae M. Fix, Nora M. Mueller, Anna M. Barker, Sherri L. Lavela, Jennifer N. Hill, Jeffrey L. Solomon, and Carol VanDeusen Lukas. "How Can Healthcare Organizations Implement Patient-Centered Care? Examining a Large-Scale Cultural Transformation." BMC Health Services Research 18, no. 168 (2018): 2–11.

Brom, Danny, Yaffa Stokar, Cathy Lawi, Vered Nuriel-Porat, Yuval Ziv, Karen Lerner, and Gina Ross. "Somatic Experiencing for Posttraumatic Stress Disorder: A Randomized Controlled Outcome Study." Journal of Traumatic Stress, no. 30 (June 2017): 304–12.

Chin-Po Paul Yang, M.D., Ph.D., William A. Hargreaves, Ph.D., and Alan Bostrom, Ph.D. "Association of Empathy of Nursing Staff with Reduction of Seclusion and Restraint in Psychiatric Inpatient Care." Psychiatry Services 65, no. 2 (February 2014): 251–54.

Craig, A.D. "The Significance of the Insula for the Evolution of Human Awareness of Feelings from the Body." Annals of the New York Academy of Sciences, New Perspectives on Neurobehavioral Evolution (2011).

Enlow, Michelle Bosquet, Byron Egeland, Elizabeth Carlson, Emily Blood, and Rosalind J. Wright. "Mother–Infant Attachment and the Intergenerational Transmission of Posttraumatic Stress Disorder." Development and Psychopathology, 2013.

Epstein, Mark. The Trauma of Everyday Life. Penguin Books, 2014.

Evans, Crystal A., Judy Thomas, and Sharon MacDonnell. "Interpersonal Problems of the Nonprofit Workforce: Evaluating the Wounded Healer as the Reason for High Turnover." Journal of Ideology 39, no. 1 (October 2018): 1–31.

Felitti, MD, FACP, VIncent J., Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, PhD, Alison M. Spitz, MS. MPH, Valerie Edwards, BA, Mary P. Koss, PhD, and James S. Marks, MD, MPH. "Relatiohship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine 14, no. 4 (1998): 245–58.

Geller, Shari M. and Stephen W. Porges. "Therapeutic Presence: Neurophysiological Mechanisms Mediating Feeling Safe in Therapeutic Relationships." Journal of Psychotherapy Integration 24, no. 3 (2014): 178–92.

Hernandez-Wolfe, Pilar. "Vicarious Resilience: A Comprehensive Review." Revista de Estudios Sociales 66 (2018).

Hensel, Jennifer M., Carlos Ruiz, Caitlin Finney, and Carolyn S. Dewa. "Compassion Fatigue: A Meta-Narrative Review of the Healthcare Literature." Journal of Traumatic Stress 28, no. April (2015): 83–91.

Holmes, RN, PhD, David, Suzanne Kennedy RN, MSc(A), and Amelie Perron, RN, BScN. "The Mentally Ill and Social Exclusion: A critical examination of the use of seclusion from the patient's perspective." Issues in Mental Health Nursing 25 (2004): 559–78.

Lawn, Sharon, Toni Delany, Mariastella Pulvirenti, Ann Smith, and John McMillan. "A Qualitative Study Examining the Presence and Consequences of Moral Framings in Patients' and Mental Health Workers' Experiences of Community Treatment Orders." BMC Psychiatry 15, no. 274 (2015): 1–17.

©2018 COPYRIGHT BY TIMBO

{TIMBO}

REFERENCES, cont.

Leitch, Laurie. "Action Steps Using ACEs and Trauma informed Care: A Resilience Model." Health and Justice 5, no. 5 (2017).

Manyema, Mercy, Shane A. Norris, and Linda M. Richter. "Stress Begets Stress: The Association of Adverse Childhood Experiences with Psychological Distress in the Presence of Adult Life Stress." BMC Public Health 18, no. 835 (2018): 1–12.

Mate, M.D., Gabor. When the Body Says No: The Cost of Hidden Stress. Vintage Canada, 2004.

Meier, Kenneth J., Sharon H. Mastracci, and Wilson Wilson. "Gender and Emotional Labor in Public Organizations: An Empirical Examination of the Link to Performance." Public Administration Review, December 2006.

Mohammadreza Hojat, PhD, Daniel Z. Louis, MS, Fred W. Markham, MD, Richard Wender, MD, Carol Rabinowitz, and Joseph S. Gonnella, MD. "Physicians' Empathy and Clinical Outcomes for Diabetic Patients." Academic Medicine 86, no. 3 (March 2011): 359–64.

Muskett, Coral. "Trauma-Informed Care in Inpatient Mental Health Settings: A Review of the Literature." International Journal of Mental Health Nursing (2013): 1–9.

O'Conner, Karen, Dierdre Muller, and Steve Pitman. "Burnout in Mental Health Professionals: A Systematic Review and Meta-Analysis of Prevalence and Determinants." European Psychiatry 53 (2018): 74–99.

Paulus, Martin P., Jennifer L. Stewart, and Lori Haase. "Treatment Approaches for Interoceptive Dysfunctions in Drug Addiction." Frontiers in Psychiatry 4 (2013).

Patsiopoulos, Ariadne T., and Marla J. Buchanan. "The Practice of Self-Compassion in Counseling: A Narrative Inquiry." Professional Psychology: Research and Practice 42, no. 4 (August 2011): 301–7.

Purtle, Jonathan. "Systematic Review of Evaluations of Trauma-Informed Organizational Interventions That Include Staff Trainings." Trauma, Violence & Abuse (2018): 1–16.

Rogers, Carl. Significant Aspects of Client-Centered Therapy. Edited by David Webb. www.all-about-psychology.com, 2013.

Rothschild, Babette. The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment. 1st ed. W. W. Norton & Company, 2000.

Sinclair, Shane, Shelley Raffin-Bouchal, Lorraine Venturato, Jane Mijovic-Kondejewski, and Lorraine Smith-MacDonald. "Compassion Fatigue: A Meta-Narrative Review of the Healthcare Literature." International Journal of Nursing Studies 69 (2017): 9–24.

Sweeney, Angela, Beth Filson, Angela Kennedy, Lucie Collinson, and Steve Gillard. "A Paradigm Shift: Relationships in Trauma-Informed Mental Health Services." BJPsych Advances 24 (2018): 319–33.

Weilenmann, Sonja, Ulrich Schnyder, Brian Parkinson, Claudio Corda, and Roland von Kanel. "Emotion Transfer, Emotion Regulation, and Empathy-Related Processes in Physician-Patient Interactions and their Association with Physician Well-Being: A Theoretical Model." Frontiers in Psychiatry, Hypothesis and Theory, 9 (August 28, 2018): 1–18.

©2018 COPYRIGHT BY TIMBO

ACKNOWLEDGEMENTS:

The author would like to thank the following individuals for their support, editing expertise and encouragement: Risette Zoe MacLaren, Director of Development and Evaluation for The TIMBo Collective; Lynn Eikenberry, board member for The TIMBo Collective; Shenandoah Gale, Associate Director for Evaluation & Learning at N Street Village, Washington D.C.; Deed McCullum, former Director of Patient Access at Boston Medical Center and TIMBo Collective board member; Nan Herron, M.D., adult and child psychiatrist; and Krista Luton, editor at Words by Krista.

ABOUT THE AUTHOR:

Sue Jones is the founder of The TIMBo Collective (formerly yogaHOPE) and developer of the TIMBo program and method. Sue graduated from RISD, an elite art and design college, and went on to become a successful small business owner and travel the world before her journey into yoga for trauma. After a devastating family and personal crisis, she found relief from severe depression in mindfulness practice. The TIMBo Curriculum and Method were designed to help women change from the inside out—the only space that they (or truly any of us) had control. TIMBo is rooted in neurobiology, polyvagal and attachment theory, somatic experiencing, mindfulness, yoga, chakra theory, feminist psychology, and trauma-informed practices.

THE TIMBO COLLECTIVE

TRAUMA RESPONSIVE INNOVATIONS FOR MIND AND BODY

89 South Street
Suite 700
Boston, Ma 02111
www.yhtimbo.org