RESILIENCE TRAUMA AND PASTORAL RECOVERY

A briefing for faith communities

Professor Jim McManus, 2022

Contents

Adapted and based on *Resilience and coping beyond the pandemic - A briefing for Public Health Teams* by Jim McManus[1]

[1] Jim McManus (2021). *Resilience and coping beyond the pandemic - A briefing for Public Health Teams.* London: Association of Directors of Public Health.

Introduction

Pastoral care is "that aspect of the ministry of the Church which is concerned with the well-being of the individual and of the community in general." [2] It is clear that the impact of multiple traumas from the COVID-19 pandemic creates a major challenge for pastoral care. The purpose of this publication is to enable faith leaders to get some rapid and concise orientation on the issues of population and community trauma, resilience, self-care and coping during and beyond the pandemic, so they can consider strategies both for their congregations and the wider community.

This briefing seeks to provide some frameworks for response to the needs of:

1. **Populations and local communities**, because there will be multiple and differential impacts on various sub-populations both by life course stage and by identity, as well as socioeconomic status. Impacts are multiple, from losing loved, to losing jobs, to having essential treatment delayed. All of these can be traumatic.

2. **Faith communities**, because as the pandemic goes on, and we are now beyond 18 months of response, the risks of compassion fatigue, burnout and traumatic stress to congregations increase. Psychological injury to those who are involved in 'frontline' ministry, both as ministers or as medical and care workers, may be worse than in other parts of the population because the combination of enduring stress and their own motivation to keep serving their populations may result in their feeling unwilling or unable to seek help.

This briefing is set within the context of public mental health, which means it intentionally seeks to consider what can be done at population level (e.g. whole church or workplace), and group level, not just individual level. The right kind of action aimed at populations is just as important as action aimed at individuals and should be seen as complementary. This is especially so where there are resources and capabilities which churches can bring to bear for their whole membership, and which can help them respond to trauma and become resilient. In this sense, a population-health approach sits well with the idea of the Church as a community where healing can occur.

> COVID-19 is not a pandemic but a syndemic: a coming together of multiple impacts (loss, fear, isolation, financial impacts) which can combine and interact to create a “multiple whammy”. People may be able to withstand one or two impacts, but not the multiple combined impacts

This briefing is just that: it is intentionally brief and seeks to provide pointers with links to further reading for faith and community leaders. It is also about the ongoing and enduring after-effects and impacts of trauma rather than the immediate ones. These enduring aftereffects present a major challenge to the health and wellbeing of our communities and need to be recognised as such.[3] We seek to help readers find their bearings, provide a framework for action and signpost to further resources. Where possible, I have linked to reading resources which are free and easily accessible, rather than items which are behind a paywall, although some of the resources and tools (such as Mental Health First Aid) are traded. So, where a

[2] Campbell, V. A. (1987). *A Dictionary of Pastoral Care*. London: SPCK. P. 188.
[3] Liu, X., Zhu, M., Zhang, R. *et al.* Public mental health problems during COVID-19 pandemic: a large-scale meta-analysis of the evidence. *Transl Psychiatry* **11,** 384 (2021). (doi.org/10.1038/s41398-021-01501-9)

summary article of good quality is available which summarises a book, for example, I include that in references.

Two frameworks for post-traumatic growth

It is vital to both understand how people can find events and experiences traumatic and understand what we can do as churches to prevent trauma, respond to it, and support people on post-traumatic growth.[4] The term "post-traumatic growth" comes from Tedeschi et al., who were focused on how people recover from and grow beyond traumatic experiences. This is part of a growing emphasis in different fields of psychology on flourishing and recovery.

There is more than one framework to choose from. In Appendix 2, you will find the **Slade et al.**'s framework for post-traumatic growth, which some find helpful, but others find too extensive. A simpler framework is advanced by **Scott Barry Kaufman** who summarises the core insights from research and evidence on post-traumatic growth in the *Scientific American* blog.[5] He talks of "seven areas of growth" which "have been reported to spring from adversity:

- Greater appreciation of life
- Greater appreciation and strengthening of close relationships
- Increased compassion and altruism
- The identification of new possibilities or a purpose in life
- Greater awareness and utilisation of personal strengths
- Enhanced spiritual development
- Creative growth

We could benefit from a greater emphasis on spiritual development and on the riches of the churches across scripture, personal and organised worship and prayer, pastoral care practices and traditions and more. But different churches will have different emphases (e.g. a Methodist and a Roman Catholic approach to spiritual development will have both similarities and differences) and now that the point is made that spiritual development is important in growth after trauma, churches can consider what that means for them as part of reflecting through what they do.

Churches and congregations have a natural interest in supporting people to grow in many ways: as persons, after trauma, in discipleship and friendship with Christ. And they have resources, traditions and capabilities which can help people. From the sacraments to providing safe space, from journeying with people to helping them through pastoral care and much more, responding to trauma, helping people grow beyond it and helping them be resilient can be an important way of living out the Church's mission post-pandemic.

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[4] See What doesn't kill us...; The Psychologist (thepsychologist.bps.org.uk/volume-25/edition-11/what-doesnt-kill-us)
[5] See Post-Traumatic Growth: Finding Meaning and Creativity in Adversity; Scientific American (blogs.scientificamerican.com/beautiful-minds/post-traumatic-growth-finding-meaning-and-creativity-in-adversity/)

The impact of COVID-19 at population, faith community and ministry team levels

Following Singer (2009[6]), Horton and others (2020[7]) have pointed out that COVID-19 is not a pandemic but a syndemic: a number of impacts (physical, social, financial or emotional) which combine together to have an effect which is worse than any one individually. Some people may describe this as a "multiple whammy". Singer describes these various impacts as acting synergistically (i.e. working together to have a greater impact than the sum of their parts). So, for example, COVID-19 has physical, psychological, economic and social impacts on people which have multiple causes: losing loved ones from COVID-19, losing jobs, as well as suffering the effects of isolation, for example. The syndemic lens is an important one for faith leaders (those primarily based in the community) to use in both understanding multiple waves and dimensions of the impact of COVID-19, and in understanding the multiple issues to be faced in recovery. There is a growing and extensive literature on syndemic impacts of HIV, mental health, disaster and trauma.

Most faith communities have a workforce, often with a formal ministry team and many informal volunteers. Most of them may be unpaid volunteers, but they still constitute a workforce, and these workforces have often borne the brunt of coping with the impact of COVID-19 on others as well as themselves. They need some specific attention and care.

Faith leaders face two major sets of mental health challenges coming out of the pandemic: the major collective traumatic impact of COVID-19 on **populations and individuals**, and the impact on **ministers and workforces** (paid or unpaid).

Major collective trauma

There is very strong evidence that the COVID-19 pandemic has affected people not only individually but also collectively.

It has been a "major collective trauma", which affects most people psychologically or emotionally in one way or another. The impact of this varies from person to person, and community to community, and is dependent on a number of factors. While everyone has experienced some trauma, some people have experienced much more than others. The trauma of being locked down is different from the very serious trauma of serious illness and bereavement. The evidence suggests that the effect is greater the closer you are to the "storm".

[6] Singer, M. (2009). *Introduction to syndemics: a critical systems approach to public and community health*. San Francisco, CA: Jossey-Bass. Online: available at site.ebrary.com/id/10310638

[7] Horton, R. (2020). Offline: *COVID-19 is not a pandemic.* The Lancet, 396(10255), p.874. DOI: doi.org/10.1016/S0140-6736(20)32000-6

While some people will recover and thrive, others will struggle at various degrees. This is a clear challenge. When it comes to mental health services run by the health system, the demand and need will be some way beyond capacity, and we must therefore identify a population-wide approach to early intervention, prevention and recovery. There are multiple and enduring impacts of this from the disrupting of daily life, loss of lives, major economic disruption and breakdown of psychological, social and emotional routines and connections. This happens both individually and socially. To quote Demertzis and Eyerman (2020[8]):

> There can be little doubt that the ongoing COVID-19 pandemic poses a global threat that has created crisis on many levels, from local communities to states and nations. As Eric Woods et al. (2020) put it, 'It has significant potential to trigger multiple, cascading crises in nearly every aspect of our lives. In addition to the presence of a threat, crises typically involve systemic disruption, uncertainty and stress'.[9] A cultural trauma is a form of crisis, a crisis of identity that affects individuals and collectives. Both Greece and Sweden experienced severe crisis during the first stages of the pandemic yet neither, to this point, have developed into cultural traumas. No matter how severe, not all crises become cultural traumas and the point of our comparison is to explain why.

Grief and shock from this can turn into many things, including grievance and intolerance. Collective traumas like the disruption from COVID-19 involve social, not just physical, threats.

Ministry teams and workers

Ensuring you and your ministry teams (employed and volunteers) are resilient and supported is crucial to be able to continue the journey to recovery.

The sustained nature of response to the pandemic, and the fact that we do not yet have an endgame, means that those in positions of leadership and responsibility, which in faith settings often goes very much beyond paid staff, are under increasing pressure and ongoing stress. Standing down teams who have been on what feels like a battle footing for some time is in and of itself a task which needs careful handling. This is an organisational wellbeing and resilience challenge. Not addressing the needs of leaders (e.g. ministers, chaplains, children's workers, youth pastors, small groups leaders) while addressing the needs of others risks creating a strong sense of unfairness and creating further trauma. Caring for the carers and self-care have to be an essential part of responding meaningfully to trauma.

[8] Demertzis, N. and Eyerman, R. (2020). *COVID-19 as cultural trauma.* American journal of cultural sociology, 1–23. Advance online publication: doi.org/10.1057/s41290-020-00112-z

[9] Demertzis, N., & Eyerman, R. (2020). *COVID-19 as cultural trauma*. American journal of cultural sociology, 1–23. Advance online publication. doi.org/10.1057/s41290-020-00112-z

What might a framework for churches and congregations look like?

Mentioned in the introduction are two frameworks for post traumatic growth. But these alone are insufficient for church and pastoral response. There is significant space here for faith-based responses, and indeed faith communities can bring some specific resources and expertise to this. So a simple plan for what churches might do can be adopted, and whichever framework on post-traumatic growth you decide to use can be integrated into this.

There are four points to such a plan:

1. Responding to trauma needs to be theologically grounded.
2. Responding to trauma needs to be informed by the best available evidence of what can help people recover, grow and heal. It must also do no harm.
3. Responding to trauma needs to incorporate care for the responders. Self-care is as important as "other care".
4. There are resources and tools in existence which can be used, and we make recommendations here. These are not exhaustive but are intended to be helpful.

The rest of this briefing seeks to follow this structure and provide useful resources and pointers.

Responding to trauma needs to be grounded theologically

Responding to trauma needs to be grounded theologically and embodied in the life, worship and mission of faith communities. There are growing resources for faith communities here in beginning to do this. There is growing impact from trauma studies on theology.[10] Most people have experienced a traumatic event, or an ongoing series of them. This movement is perhaps more impacted by psychoanalytic aspects of trauma studies, and recent evidence on group and social levels of trauma needs to be included.

Recent research in social psychology suggests both an opportunity for faith communities in helping people grow beyond trauma and a risk. The opportunity is that positive social identities (feeling part of a cohesive, supportive, purposeful community which has a social identity and reinforces my personal identity positively) can support people to grow and be resilient through trauma. This is often termed the "social cure". Examples of this abound from supportive relations among asylum seekers to mutual care between people from Black, Asian and Minority Ethnic communities or LGBTQ people and their networks, and mutual support in the face of hate crime. The negative side of this is that where trauma, or communities, undermine peoples' social and personal identities, then people can be less resilient or even re-traumatised by unsupportive or negative social identities. The work of Muldoon et al. is helpful in this context.[11] Faith communities which purposively build authentic, positive, inclusive prosocial identities will be more resilient places to grow beyond trauma, of all kinds, not just collective COVID-19 trauma. This presents a great opportunity for churches.

This leads us to two significant questions for faith communities:

1. How do we respond to trauma in ways that help people make sense of it and grow beyond it in our practice, our liturgy and worship, and our pastoral care and social service?

2. How do we – wittingly or unwittingly – undermine efforts to support resilience or, even worse, re-traumatise people or reinforce their trauma by bad theology or pastoral care?

A detailed exposition is beyond the scope of this document but using insights from trauma studies for theological reflection offers rich opportunity for healing and growth. Some useful brief orientations can be found in Rambo[12] (2019) and Marin[13] (2014). I have tried to incorporate insights and tools into the plan for sake of time, but this is no replacement for undertaking some specific learning and theological reflection, and I include a section on further reading and resources aimed at supporting this.

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[10] See How Christian theology and practice are being shaped by trauma studies; The Christian Century (christiancentury.org/article/critical-essay/how-christian-theology-and-practice-are-being-shaped-trauma-studies)

[11] Orla T. Muldoon, S. Alexander Haslam, Catherine Haslam, Tegan Cruwys, Michelle Kearns & Jolanda Jetten (2019). *The social psychology of responses to trauma: social identity pathways associated with divergent traumatic responses*, European Review of Social Psychology, 30:1, 311-348, DOI: doi.org/10.1080/10463283.2020.1711628. For full article, see: The social psychology of responses to trauma: social identity pathways associated with divergent traumatic responses; Taylor & Francis Online (tandfonline.com/doi/full/10.1080/10463283.2020.1711628) and Community identity and collective efficacy: A social cure for traumatic stress in post-earthquake Nepal; Wiley Online Library (onlinelibrary.wiley.com/doi/abs/10.1002/ejsp.2330)

[12] See How Christian theology and practice are being shaped by trauma studies; The Christian Century (christiancentury.org/article/critical-essay/how-christian-theology-and-practice-are-being-shaped-trauma-studies)

[13] See Pastoral care to those suffering from traumatic memories (biblesociety.org.uk/uploads/content/bible_in_transmission/files/2014_summer/BiT_Summer_2014_Marin.pdf)

Developing an evidence-based, trauma informed recovery plan as a faith community

An individual focus on trauma, while necessary and valuable to help people recover and cope individually, is not sufficient in and of itself to enable a population to recover from what is a collective trauma.

The concepts of collective trauma[14], developed from disaster and conflict psychology, offer a lens which is at population level, and should be helpful for faith and community. Collective trauma refers to an event, or series of events, that is psychologically or emotionally stressful for a group of people, which can be anything from a small group (e.g. a friendship group which experiences a sudden traffic accident) to a whole population.

- Traumatic experiences can lead to a variety of physiological, psychological, relational, spiritual, and societal responses.
- Some people emerge from a traumatic experience relatively unscathed and adjust well. Recent evidence from conflict and war psychology shows strong positive group identity accompanied by mutual support within the group can contribute to adjustment and coping and almost become a "social cure." Similarly, as mentioned above, group identity can also worsen or continue stigma and trauma.
- People may become changed for a short, medium, or very long period by a traumatic event.
- The exact degree of differential responses to traumatic experiences depends on a variety of factors, including prior trauma history, current stressors, level of resilience, and the degree to which there are meaningful relationships.

People don't need to have experienced the event first-hand in order to be changed by it. We know that some people can experience trauma from witnessing traumatic events on television, for example.

Most people have experienced a change in their lives beyond their control (e.g. lockdown) through COVID-19. This can traumatise people in different ways, and there are a range of ways in which the grief and trauma can express itself, including frustration, grievance and protest against public health measures. Some become much more open to believing conspiracy theories. Others may become anxious or depressed and be fearful of returning to normal social life after the pandemic ends or when restrictions ease.

At identity-group level (e.g. populations of identity or teams within organisations) trauma can be both a galvanising factor to seek or even to organise self-help (e.g. responses to hate crime) and a source of further deep stigmatisation and difficulty. In some people, trauma experiences will lead to clinical-level mental health conditions including PTSD and complex grief. This isn't just about short-term behavioural effects but risk factors for serious and enduring illness.

[14] The work of Reimann and Konig (2017) in particular can provide a useful lens to use in understanding collective trauma. See Cordula Reimann and Ursula König (2017). Collective Trauma and Resilience. Key Concepts in Transforming War-related Identities. Comment on: Transforming War-related Identities. Berghof Handbook Dialogue Series No. 11, edited by Beatrix Austin and Martina Fischer. Berlin: Berghof Foundation 2016. (berghof-foundation.org/library/collective-trauma-and-resilience-key-concepts-in-transforming-war-related-identities)

Collective trauma, when aligned to public health concepts of 1) looking at populations and sub-populations and 2) syndemics, is an extremely valuable concept to use. Together, these three concepts can provide a "tri-focal" lens ideally suited to consider the impact of the pandemic. The pandemic impacts at population, sub-population and individual levels. We also know that the impacts of COVID-19 have not been equal. Those who are most deprived, Black, Asian and Minority Ethnic communities, and those in jobs who were unable to work from home have experienced the worst impacts. Caregivers (paid and unpaid) have also experienced significant impacts.

It is often assumed that the response to trauma is to provide counselling and therapeutic interventions for everyone. While this can and does have value when the interventions are run by people properly trained and experienced in trauma, there are other things that should be done.

- "The Social Cure": how can your church as a community help people recover and grow? Is your church and worship welcoming and inclusive?
  - Does it accept the reality of peoples' hurt or does it encourage people not to voice or express it? Do relationships between members build resilience, understanding and support?
  - How welcoming can you make your church and congregation? Are people understanding of others' trauma? Are people able to welcome?
  - Using the Friendly Places framework may be a good place to start Friendly Places: Mental Health - FaithAction because it provides a baseline of welcoming and inclusive practices that can help people feel safe.
  - Do you manage conflict well? If not, you may try the resources from Bridge Builders (bbministries.org.uk)
- "Do no harm": do you know what NOT to do in response to people who are traumatised? If not, check out Appendix 3. This is especially important in relation to avoiding practices which may re-traumatise people.
- How do you help people to grow using your traditions and resources? (Revisit the frameworks on post-traumatic growth suggested).
- Telling and retelling my story: the role of storytelling in recovering one's identity and growing after trauma is becoming more recognised, but this has to come from the person, not be forced or coaxed by others.
- If it is decided to do this in a group or liturgical setting (e.g. someone telling their story) it needs to be very well organised and have clear ground rules in case people are distressed. This needs to be done with great care not to re-traumatise people and avoid distressing people or making them relive events. Grosch-Miller's *Trauma and Pastoral Care* has some useful guidelines[15].
  - Arthur Frank's book *The Wounded Storyteller*[16] is a valuable resource to help exploration and action on this.
  - Badly run, storytelling can harm as well as help. The US National Association of State Mental Health Program Directors has a useful tool to work through as part of its Peer

[15] Grosch-Miller, C. (2021). *Trauma and Pastoral Care*. Norwich: Canterbury Press.
[16] Frank (2013). *The Wounded Storyteller: Body, Illness and Ethics*. Chicago: University of Chicago Press.

Engagement Guide.[17] [18]

- Both the British Psychological Society and American Psychological Society have provided some free resources on this.[19,20]

- Physical therapies can also help. Van der Kolk[21] has researched the role of the body in recovery and embodiment of trauma. The provision of relaxation, yoga, or gentle exercise classes, even engagement with activities like swimming and horticulture, can be important adjuncts to post-traumatic recovery and growth. When combined with supportive groups (e.g. an organised church activity) this can gain the best of group identity support ("the social cure") with physical exercise. What could your church or faith community do on this?

[17] See Peer Engagement Guide: Trauma-Informed Storytelling (nasmhpd.org/sites/default/files/PeerEngagementGuide_Color_CHAPTER11.pdf)
[18] See Engaging Women in Trauma-Informed Peer Support: A Guidebook; National Association of State Mental Health Program Directors (nasmhpd.org/content/engaging-women-trauma-informed-peer-support-guidebook)
[19] See Growth after trauma; American Psychological Association (apa.org/monitor/2016/11/growth-trauma)
[20] See What doesn't kill us...; The Psychologist (thepsychologist.bps.org.uk/volume-25/edition-11/what-doesnt-kill-us)
[21] Van der Kolk, Bessel (2014). *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma*. Harmandsworth: Penguin.

Resilience, ministry care and enabling self-care: no care for others without care for self

There are multiple challenges for faith/ministry 'workforces' during and beyond the pandemic which will cause stress. Taken together, if people do not perceive they have the ability to manage these multiple stressors, then their mental health, activity, and general health can suffer.

There are multiple issues which can affect people in the workplace (whether they are volunteers or paid) of varying intensity. It is possible for people to experience more than one of these at different times or even at the same time.

- **Stress** – the reaction we have when the demands we perceive on us in a situation, or our workload, are greater than our perceived resources to meet them. This can be short or long term.
- **Traumatic stress** – a specific, more intense, and more complex type of stress that reflects exposure to terrible events that are emotionally painful, intense, or distressing. Can be accompanied by multiple challenges.
- **Moral injury** – there is a risk of 'moral injury' where people either witness or carry out acts that go against their moral code (e.g. having to deny someone a service or promote interventions which conflict with their values). While this is better understood in relation to the armed services, it has some resonance during COVID-19 and is a risk factor for later mental illness[22], especially among medical workers who are part of the worshipping community.
- **Compassion fatigue** – emotional and physical exhaustion compounded by "caring without ceasing" leading to a diminished ability to empathise or feel compassion for others.
- **Burnout** – a syndrome resulting from chronic workplace stress that has not been successfully managed. It is characterised by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's role, or feelings of negativism or cynicism related to one's role; and reduced professional and personal efficiency. This can rapidly become a serious problem for individuals outside and inside work.

There are however a range of things which can be done to support workforces, and most recently work on workplace wellbeing and crisis and trauma psychology has come together to create a menu of approaches. These are incorporated into the menu of resources below. Different groups will find different things useful.

[22] Williamson et al. (2021). *Moral injury: the effect on mental health and implications for treatment*. The Lancet Psychiatry, Volume 8, Issue 6, P. 453-455, June 01, 2021. See Moral injury: the effect on mental health and implications for treatment; The Lancet Psychiatry (thelancet.com/journals/lanpsy/article/PIIS2215-0366(21)00113-9/fulltext)

Menu of resources from individual to church and workforce levels

It is important to recognise that there are some things that will make a church or community welcoming and inclusive and there are some things that will make it feel safe (e.g. the Friendly Places tool mentioned in the menu). It is best to consider these resources as complementary parts of making a church or community safe, welcoming, inclusive and supportive.

The table below is designed to provide a menu of resources to choose from. The appendices also provide some supplementary resources and materials. There are some things to bear in mind in using this menu:

This menu is

1. Intended to help you identify what you can do, beginning with yourself, before thinking about smaller groups and then the main congregation.
2. A reflective tool for action. What are you already doing? What are you not doing?
3. Designed to help you think about the immediate, and the longer term.
4. Intended to start with what you can do to care for yourself before moving to individual congregation/community members, then to small groups, and finally the whole church or organisation.

This menu is not

1. A benchmark. You should not use this to judge what you are not doing. Instead, take from it what is useful for you and what is achievable.
2. Either exhaustive or compulsory. There are other useful tools out there not included.
3. Going to turn you into expert trauma therapists. It is simply a guide to help you respond to trauma and help people grow beyond it.

The immediate and the long term: Psychological First Aid versus Mental Health First Aid

Mental Health First Aid (MHFA)

Mental Health First Aid (MHFA) is designed to give immediate support across a broad range of mental health issues. It is a way of training and applying techniques that will help people identify and respond sensitively and appropriately to signs of mental health problems where people can benefit from the right kind of immediate support, plus signposting to appropriate help. (mhfaengland.org)

Psychological First Aid (PFA)

PFA is specifically designed to provide support in the aftermath of a traumatic event in a way that helps them stay safe and stops them from worsening.

Both tools can have an "acute" (i.e. short term) or longer-term focus, but MHFA is broader than PFA. Having people who know both is good, and PFA training doesn't take long. Public Health England have a three hour online free course more aimed at people who work with children and young people. (futurelearn.com/courses/psychological-first-aid-for-children-and-young-people) We provide links below for Adult Psychological First Aid tools. For those already trained or experienced (e.g. emergency responders), Appendix 4 gives a summary of psychological first aid tips suitable for all ages.

Neither of these two tools replaces the other. Both are good to have.

A menu of actions, tools and resources to choose from and reflect on

Individual level (Self)

Actions

Any of these approaches can be used. Some work for others. It is important to have a self-care plan or resilience plan of some kind. More about this is provided below.

- Self-care plan
- Self-acceptance
- Self-compassion
- Personal resilience plan
- Self-care buddies

Resources

- How to Make a Self-Care Checklist; Healthline (healthline.com/health/self-care-checklist)
- Mind Plan Quiz; Every Mind Matters (nhs.uk/every-mind-matters/mental-wellbeing-tips/your-mind-plan-quiz/)
- Managing Personal Resilience; Derek Mowbray (mas.org.uk/management-advisory-service/managing-resilience.html)
- Your Wellbeing Journal; Livability (livability.org.uk/news/wellbeing-spirituality/your-wellbeing-journal/)

What are you doing now? What helps? What may need changing?

What could you do?

Individual level (Others)

Actions

The resources opposite are designed to help busy teams.

There are several important dimensions to supporting individuals.

- Encouraging people to self-care.
- Leading by example to show compassionate leadership and encourage a culture of support.
- Identifying signs of when people are not coping.
- Identifying sources of help within the organization.
- Signposting people to relevant support.

How many of your pastoral carers know the basics of how to respond to trauma?

Resources

- Thriving when work is tough: in COVID and non-COVID times; The British Psychological Society (youtu.be/jLdih0hQ6FA)
- Podcast: Promoting and supporting good mental health; CIPD (cipd.co.uk/podcasts/promoting-supporting-good-mental-health)
- Managing Personal Resilience; Derek Mowbray (mas.org.uk/management-advisory-service/managing-resilience.html)
- Mental Health At Work (mentalhealthatwork.org.uk)
- Training: Mental Health First Aid (mhfaengland.org)
- Course: Psychological First Aid: Supporting Children and Young People; Future Learn (futurelearn.com/courses/psychological-first-aid-for-children-and-young-people)
- Coping after a traumatic event; Royal College of Psychiatrists (rcpsych.ac.uk/mental-health/problems-disorders/coping-after-a-traumatic-event)
- Helping someone through trauma; Mind (mind.org.uk/information-support/types-of-mental-health-problems/trauma/for-friends-and-family/)
- The Mental Health Access Pack (mentalhealthaccesspack.org)
- Hub of Hope (hubofhope.co.uk)

What are you doing now? What helps? What may need changing?

What could you do?

Pastoral team or group level

Actions

- Good teamworking is positively associated with better resilience.
- Encourage peer to peer support.
- Create a favourable social and working climate.
- Gatherings or clusters.
- Connecting – getting together, actively and openly listening.
- Provide team support – physical environments to have breaks, social connection when people are virtual etc.
- Ensure people get some downtime.
- Creating team rules and norms which support healthy work patterns.
- Praying together.
- Bible study as a way of supporting people to tell their story on trauma.
- Ensuring your pastoral team and liturgies are alert to not re-traumatizing people.

Resources

- Wellbeing; Local Government Association (local.gov.uk/our-support/workforce-and-hr-support/wellbeing)
- Managing Personal Resilience; Derek Mowbray (mas.org.uk/management-advisory-service/managing-resilience.html)
- Mental Health At Work (mentalhealthatwork.org.uk)
- Course: COVID:19: Psychological First Aid; Future Learn (futurelearn.com/courses/psychological-first-aid-COVID-19)
- The Mental Health Access Pack (mentalhealthaccesspack.org)
- Supporting Survivors of Trauma: How to Avoid Re-traumatization; Online MSW Programs (onlinemswprograms.com/resources/social-issues/how-to-be-mindful-re-traumatization/)

What are you doing now? What helps? What may need changing?

What could you do?

Organisational: a welcoming, trauma-informed and inclusive church

Actions

- Making your church a welcoming and inclusive space where people who have had traumatic experiences can feel safe.
- Having individuals on hand who can provide support.
- Creating a safe space for people who are or become distressed during worship or events.
- Ensuring you know what NOT to do, especially **do not debrief people**.
- Understanding what your church does to both heal and harm (for example, facilitating contact between others, providing space, providing activities, well thought through healing or trauma liturgies, organizing groups, and more.)
- Training some of your church members in Mental Health First Aid (a useful foundation for future action).
- Providing some training and study and practical tools on mental health inclusion.
- Finding healthy ways to address conflict.

Resources

- Friendly Places: Mental Health; FaithAction (faithaction.net/friendlyplaces/)
- Course: COVID:19: Psychological First Aid; Future Learn (futurelearn.com/courses/psychological-first-aid-COVID-19)
- Healthy Healing Hubs; GoHealth (gohealth.org.uk/hhh/)
- Training: Mental Health First Aid (mhfaengland.org)
- Sanctuary: Mental Health Ministries (sanctuarymentalhealth.org)
- Tragedy and Congregations (tragedyandcongregations.org.uk)
  - The project has also created two books; *Tragedy and Congregations: a Practical Theology of Trauma* (2019) and *Trauma and Pastoral Care: A Practical Handbook* (2021).
- Bridge Builders Ministries (bbministries.org.uk)

What are you doing now? What helps? What may need changing?

What could you do?

Organisational level (but specifically workforce)

Actions

- Implement the Thriving at Work framework.
- Leaders must signal and model that mental health is taken seriously.
- Encourage people to talk about what can be done.
- Self-care buddies.
- Practice compassionate, authentic leadership - embody compassion, lead by example; in return for caring for your workforce you will get a compassionate workforce: attending, understanding, empathising, helping.
- Support managers and faith leaders – care, value, and appreciate:
  - Signal staff wellbeing is a priority.
  - Recognise compassion fatigue is real.
  - Regular honest and open communications.
  - Be visible and approachable.
  - Provide feedback.
  - Provide protected breaks.
  - Provide environments where staff and volunteers can talk openly and safely with one another.
  - Think about your own wellbeing needs, create a self-care plan, and seek support if you need it.
  - Be open that you are doing this.

Resources

- How to implement the Thriving At Work mental health standards in your workplace; Mental Health At Work (mentalhealthatwork.org.uk/resource/how-to-implement-the-thriving-at-work-mental-health-standards-in-your-workplace/)
- Managing Personal Resilience; Derek Mowbray (mas.org.uk/management-advisory-service/managing-resilience.html)
- Mental Health at Work (mentalhealthatwork.org.uk)

What are you doing now? What helps? What may need changing?

What could you do?

Key skills for tough times: self-care, self-compassion and self-acceptance

Self-care is important theologically. People engaged in ministry and services – whether paid or unpaid – are often engaged in kenotic (self-giving and self-emptying) activities. The worth of the person giving, and their need to be resilient and cared for, is vital in ensuring they can keep that ministry going safely without harming themselves or others. Disciplines like prayer, time for meditation and rest are all important, but they are not the only tools to be used. A proper self-regard (I am valued, I am loved, it is right and just to care for myself and those close to me) is important in ensuring a balanced and healthy approach to ministry and service, paid or unpaid.

Self-care, self-compassion and self-acceptance are powerful tools for maintaining resilience in tough times. They are all slightly different, and they are all needed. And they are all compatible with a theology of ministry which values the worth, dignity and health of the minister, wherever that ministry falls on a spectrum of full-time ministry, to occasional ministry to others. While there are many frameworks, it is sensible to see self-compassion and self-acceptance as key dimensions within self-care.

Frameworks for self-care can often feel dizzying in their complexity. Here for now is an attempt at a straightforward framework:

1. Evaluate your coping skills – which ones are positive (e.g. downtime) which ones are negative (drinking too much, eating wrong foods)?
2. Reflect – which existing strategies work and which do not?
3. Examine whether there are barriers to self-care, what they are, and what you can do about them
4. Do you need to ask for help or support of any kind?
5. Try to revisit and identify your self-care needs each day (for many, they change from day to day)
6. Write your plan down. Find a self-care buddy who may notice when you are using negative rather than positive coping methods.
7. Try to practice **self-acceptance** – recognise these are extraordinary and difficult times and be honest to yourself and others. It is OK to feel overwhelmed at times and OK to focus on some things and not on others.
8. Try to practice **self-compassion**. Some key components are:
    a. *Self-kindness vs self-judgement* – it's not only OK to be imperfect, it's where, in our weakness, God can work. Some people may find 2 Corinthians 12 salient here. Others may find the examples of saints useful. A good biography of any saint or Christian leader shows his/her weaknesses and failings as well as strengths.
    b. *Common humanity vs isolation* – recognising others feel the same. Everyone is fighting a struggle you know little about. You are not alone.

c. *Perspective vs over-identification* – compassion can sometimes lead to over-identification, where you excessively identify commonalities of someone else's distress or situation in yourself. This can become compulsive and harmful. Put the situation into perspective and be mindful not to over identify with negative feelings and thoughts.

These tools do work for many people, but because we are all different, some will find it easier to use them than others. Some people find self-care techniques very difficult to put into practice without a framework into which to set them, which is where tools such as those suggested above for personal self-care plans or personal resilience are useful. Some further tools and frameworks are in the resources section below.

Thriving in workplaces long beyond COVID-19: looking to the future

There are multiple – and often confusing and competing! – tools for workplace mental health. The menu of interventions above is purposive and designed to point you to some things you can do now and relatively quickly.

The Thriving at Work framework (see below) has a series of standards: six Core Standards and four Enhanced Standards.

During the pandemic it is difficult to institute this in an organisation fully, since it requires clear dedicated resource, but many organisations have used these standards to provide a rapid check and implement what they can for now. It provides a thoroughgoing framework, and, while difficult to institute during pressures of a pandemic, it can be very useful in recovery.

A useful and brief tool for thriving at work during the pandemic can be found in a British Psychological Society video (youtu.be/jLdih0hQ6FA).

Thriving at work framework standards[23]

Six Core Standards

1. Produce, implement and communicate a mental health plan at work
2. Develop mental health awareness among employees
3. Encourage open conversations about mental health and the support available when employees are struggling
4. Provide your employees with good working conditions
5. Promote effective people management
6. Routinely monitor employee mental health and wellbeing

Four Enhanced Standards

1. Increase transparency and accountability through internal and external reporting
2. Demonstrate accountability
3. Improve the disclosure process to encourage openness during recruitment
4. Ensure provision of tailored in-house mental health support and signpost to clinical help

[23] See Thriving at Work guide; Mind (mind.org.uk/about-us/our-policy-work/sport-physical-activity-and-mental-health/resources/thriving-at-work-guide/)

Further reading

Reading and resources on population-level responses

- COVID-19 Public Mental Health Knowledge Hub Collaboration - a closed group but anyone working on this topic can ask to join. Jointly moderated by LGA and ADPH. (khub.net/group/COVID19-public-mental-health)

Key Reading

The Centre for Mental Health (centreformentalhealth.org.uk) has a range of tools and uses including briefings on trauma:

- Briefing 56: Trauma, mental health and coronavirus (centreformentalhealth.org.uk/publications/briefing-56-trauma-mental-health-and-coronavirus)
- Recovering at work: trauma and organisations (centreformentalhealth.org.uk/sites/default/files/publication/download/Trauma%20Guide%2023.09.20.pdf)
- Frank, Arthur W. (2013) *The Wounded Storyteller: Body, Illness and Ethics.* Chicago: University of Chicago Press.

Resource Centres

- Tragedy and Congregations (tragedyandcongregations.org.uk)
- Trauma and Shock; American Psychological Association (apa.org/topics/trauma/)
- Crisis, Disaster and Trauma Psychology Resources; The British Psychological Society (bps.org.uk/member-microsites/crisis-disaster-and-trauma-psychology-section/resources)
- Coronavirus resources; The British Psychological Society (bps.org.uk/coronavirus-resources)
- The Mental Health Access Pack, a tool specifically designed for churches to help people with mental health issues (mentalhealthaccesspack.org)

Useful Books for Faith Community Responses

- Grosch-Miller, C. (2021). *Trauma and Pastoral Care*. Norwich: Canterbury Press.

More detailed reads and books for people leading on this topic

- Schmidt, R.W. and Cohen, S.L. (2020). *Disaster Mental Health Community Planning: A Manual for Trauma-Informed Collaboration (1st ed.)*. New York: Routledge. (doi.org/10.4324/9780429285134)
- Regel, S. and Joseph, S. (2017). *Post-traumatic stress. 2nd ed*. Oxford: Oxford University Press.
- Southwick, S. and Charney, D. (2012). *Resilience: The Science of Mastering Life's Greatest Challenges*. Cambridge: Cambridge University Press. (doi.org/10.1017/CBO9781139013857)
- Tedeschi, R. et al. (2018). *Posttraumatic Growth.* London: Routledge.

Reading and Resources on Workforce Resilience, Self-Resilience and Self-Care

- Thriving when work is tough: in COVID and non-COVID times; The British Psychological Society (youtu.be/jLdih0hQ6FA)

Thriving at Work framework

- Thriving at Work: a review of mental health and employers (gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers)
- Thriving at Work guide (mind.org.uk/about-us/our-policy-work/sport-physical-activity-and-mental-health/resources/thriving-at-work-guide/)

Practically focused books, tools, training and support

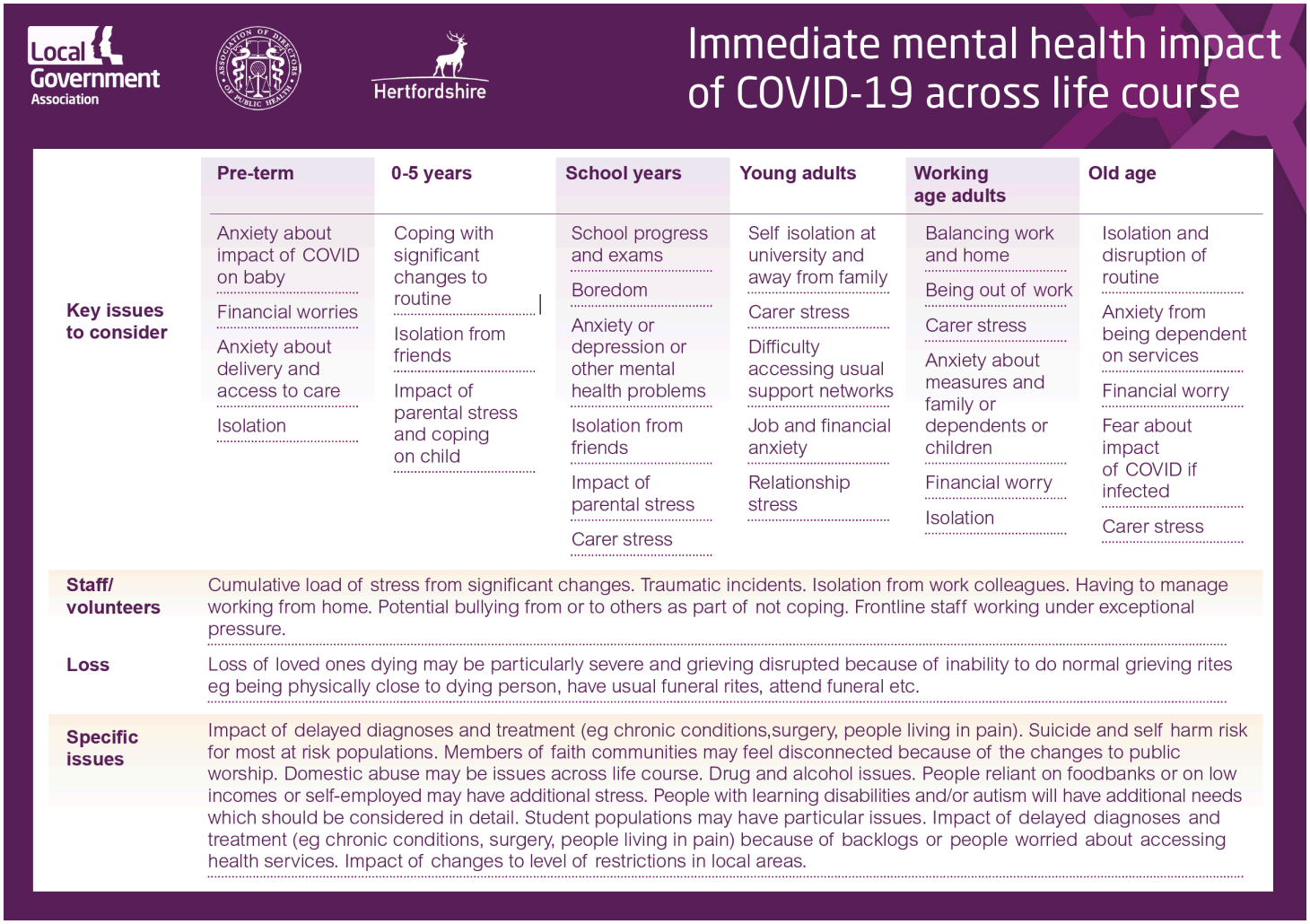
- Derek Mowbray offers managers personal guides to resilience, team guides and training. A number of directors of public health have used these because they are effective and very affordable. (mas.org.uk/publications/personal-resilience-guide.html)

Self-Care

- Your Ultimate Self-Care Assessment (with resources!); Psychology Today (psychologytoday.com/gb/blog/living-the-questions/201504/your-ultimate-self-care-assessment-resources)
- Self-Care Questionnaire and Contract (https://wellness.sfsu.edu/sites/default/files/documents/Self-Care%20Questionnaire%20and%20Contract%20%281%29%28Accessible%29.pdf)
- Mental health problems – an introduction; Mind (mind.org.uk/information-support/types-of-mental-health-problems/mental-health-problems-introduction/self-care/)
- Self-Care: 12 Ways to Take Better Care of Yourself; Psychology Today (psychologytoday.com/gb/blog/click-here-happiness/201812/self-care-12-ways-take-better-care-yourself)

Appendix 1: Life course impact ready reckoner graphics

From local.gov.uk/public-mental-health-and-wellbeing-and-COVID-19



	Pre-term	0-5 years	School years	Young adults	Working age adults	Old age
Key issues to consider	Anxiety about impact of COVID on baby Financial worries Anxiety about delivery and access to care Isolation	Coping with significant changes to routine Isolation from friends Impact of parental stress and coping on child	School progress and exams Boredom Anxiety or depression or other mental health problems Isolation from friends Impact of parental stress Carer stress	Self isolation at university and away from family Carer stress Difficulty accessing usual support networks Job and financial anxiety Relationship stress	Balancing work and home Being out of work Carer stress Anxiety about measures and family or dependents or children Financial worry Isolation	Isolation and disruption of routine Anxiety from being dependent on services Financial worry Fear about impact of COVID if infected Carer stress
Staff/ volunteers	Cumulative load of stress from significant changes. Traumatic incidents. Isolation from work colleagues. Having to manage working from home. Potential bullying from or to others as part of not coping. Frontline staff working under exceptional pressure.					
Loss	Loss of loved ones dying may be particularly severe and grieving disrupted because of inability to do normal grieving rites eg being physically close to dying person, have usual funeral rites, attend funeral etc.					
Specific issues	Impact of delayed diagnoses and treatment (eg chronic conditions,surgery, people living in pain). Suicide and self harm risk for most at risk populations. Members of faith communities may feel disconnected because of the changes to public worship. Domestic abuse may be issues across life course. Drug and alcohol issues. People reliant on foodbanks or on low incomes or self-employed may have additional stress. People with learning disabilities and/or autism will have additional needs which should be considered in detail. Student populations may have particular issues. Impact of delayed diagnoses and treatment (eg chronic conditions, surgery, people living in pain) because of backlogs or people worried about accessing health services. Impact of changes to level of restrictions in local areas.					

Impacts of Covid-19 pandemic across the lifecourse

Symbol indicates **PHOF indicator**

	Pregnancy	Infancy	Childhood	Adolescence	Adulthood	Elderly
short term	Reduced antenatal care Perinatal mental health	Perinatal mental health Breastfeeding support Immunisation uptake Non-accidental injuries	'Hidden' safeguarding issues Developmental and mental health checks not completed Adverse childhood experiences	Increased negative health behaviours Deferred sexual health services Low mood and High anxiety	Increased negative health behaviours (e.g. substance misuse, alcohol, smoking, gambling, inactivity) amongst some sections of society Paused commissioned lifestyle services, deferred cancer screening/ NHS health checks, reduced health seeking for urgent issues, 'hidden' safeguarding issues Economic uncertainty New anxiety and worsening existing mental illness, PTSD for carers/ health workers and families	Social isolation and loneliness Limited physical activity
medium term	Safeguarding risks Risky behaviours (smoking/ alcohol/ substance misuse)	Unplanned pregnancies Admissions for gastrointestinal and respiratory infections Population vaccination coverage reduced and outbreaks	Adverse childhood experiences	Increased demand for mental health services Unwanted pregnancies, STI diagnoses	Fewer recovering from substance misuse , increased BBV infections, adults smoking, adults overweight/obese Cancer screening coverage (breast, cervical, bowel) and late presentation Increased demand for grief and bereavement services, employment/ training support, claiming out of work benefits People with high anxiety	Dementia diagnosis Injuries due to falls Fuel poverty
long term	Low birthweight Poor attachment Admissions for deliberate/ intentional harm Smoking at time of delivery	Higher risk of poor mental, physical health, social and educational outcomes	School readiness	Alcohol and substance misuse admissions under 18 Obese children Admissions for self-harm	Increased demand for mental health services Under 75 mortality from cardiovascular and liver disease and cancer Worsening social inequalities Suicide	Increased morbidity and mortality

West Berkshire Council

Appendix 2: A conceptual framework for post-traumatic growth[24]

Conceptual framework for post-traumatic growth in psychosis and other severe mental health conditions. From Slade et al. 2019.

Type of growth	*Definition of the positively perceived change*
1. Self-discovery	Having a fuller and deeper understanding of oneself.
1.1 Emotional life	Discovering or re-discovering how to access, accept and be mindful of inner emotional life and difficult feelings.
1.2 Self-knowledge	Knowing oneself better, being more authentic and not being as shaped by the expectations of others.
1.3 Self-acceptance	Grieving and letting go of the past and developing self-compassion.
1.4 Self-responsibility	Taking (back) responsibility for one's own life.
2. Sense of self	Development of a more positive sense of self, including integration and valuing of illness experiences.
2.1 Pride in self	Taking pride in oneself, including personal strengths and achievements.
2.2 Integration of experiences	Illness experiences become an accepted part of one's sense of self.
2.3 Valuing of experiences	Finding positives in the experience of illness.
3. Life perspective	New or renewed appreciation of or gratitude about aspects of life.
3.1 Appreciation of life	Appreciation for life and the importance of hopefulness.
3.2 Appreciation of support	Gratitude for support received from services.
3.3 Meaningful suffering	Gratitude that suffering was meaningful and not in vain.
3.4 Survivor mission	New growth of political consciousness or use of illness experiences to benefit others.

[24] Slade M, Rennick-Egglestone S, Blackie L*, et al.* Post-traumatic growth in mental health recovery: qualitative study of narratives. *BMJ Open* 2019;**9:**e029342. See Post-traumatic growth in mental health recovery: qualitative study of narratives; BMJ Open (https://bmjopen.bmj.com/content/9/6/e029342)

4. Well-being	More active engagement in, and management of, one's own well-being and lifestyle.
4.1 Motivation	Increased determination to stay well, self-manage and not return to a bad situation.
4.2 Being active	More engagement in the arts, music, sport, nature and learning.
5. Relationships	More actively choosing and valuing relationships with others.
5.1 Choosing relationships	Actively choosing relationships to continue, to re-start or to end.
5.2 Valuing relationships	Placing more value on relationships with others.
5.3 Empathy	Enhanced ability to empathise with others.
6 Spirituality	Deeper engagement with spirituality, religious and existential endeavours.
6.1 Spiritual awareness	Increased awareness of the presence of something greater than oneself making a positive contribution by providing meaning.
6.2 Spiritual engagement	New or renewed engagement with spiritual or religious practices, helping with meaning-making and providing comfort and security.

Appendix 3: What NOT to do

Key things to avoid

It is just as important to understand what NOT to do in responding after trauma as it is to think of things to do. Here are some key things to avoid:

1. Do not re-traumatise people in individual, group, work or worship settings. This is easy to do and below are some things you should seek to avoid:
    a. Do not ask people to relive the events or attempt to "debrief" by saying things like "tell me all about it".
    b. Accept peoples' experiences and feelings as they tell them. Do not make people feel they are not being believed.
    c. Do not minimise peoples' experiences by saying things such as "oh, I had that" or "stiff upper lip".
    d. Do not ask people to speak about their experience publicly unless you have cleared it with them first. Have a "Plan B" in case they are unable to do so in the moment.
    e. Show respect for peoples' physical or emotional boundaries.
    f. Do not hold discussions in which emotional boundaries are not respected or people are made to feel like they aren't being believed.
    g. Do not pressure people to tell their story.
    h. Do not judge or assign guilt or blame.
    i. Do not be intrusive.
2. Do not share a person's story with others without their consent.
3. Do not assume one size fits all.
4. You must respect the limits of your knowledge and competence. If you are NOT an expert in trauma response and appropriately qualified, the most important thing you can do is know when to refer people on to those who are and stay within your limits.
5. Do not assume everyone needs to "get everything off their chest". Providing supportive listening is the crucial thing to do, not question people on things they found traumatic. This can be actively harmful.
6. Do not debrief unless you are trained and qualified.

Key tips

The key tips from MIND: The Mental Health Charity are extremely valuable here. (mind.org.uk/information-support/types-of-mental-health-problems/trauma/for-friends-and-family/)

Debriefing

People mean many things by "debriefing". This can range from structured debriefing as a psychological intervention practised by a fully qualified person, to a well-meaning but mistaken assumption that people should process a traumatic event as quickly as possible, talk about it in detail, re-live it or "get it off their chest". The Royal College of Psychiatrists and National Institute for Health and Clinical Excellence recommend against debriefing because it can retraumatise people and their assessment of the evidence is that it is no better, and sometimes worse, than no intervention. NICE have published an interactive flowchart of their guidance and evidence on this.[25]

[25] See Post-traumatic stress disorder overview; NICE Pathways (pathways.nice.org.uk/pathways/post-traumatic-stress-disorder#path=view%3A/pathways/post-traumatic-stress-disorder/post-traumatic-stress-disorder-overview.xml&content=view-node%3Anodes-interventions-not-to-use)

Appendix 4: Psychological First Aid

Psychological First Aid is a framework developed by the National Center for Post-Traumatic Stress Disorder in the USA and has since been used extensively in Australia and internationally, promoted by the World Health Organisation. It is defined as an "evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism to reduce initial distress and to foster short- and long-term adaptive functioning."

The World Health Organisation[26] (2011) says of it that it "describes a humane, supportive response to a fellow human being who is suffering and who may need support. PFA involves the following themes:

- Providing practical care and support, which does not intrude.
- Assessing needs and concerns.
- Helping people to address basic needs (for example, food and water, information).
- Listening to people, but not pressuring them to talk.
- Comforting people and helping them to feel calm.
- Helping people connect to information, services and social supports.
- Protecting people from further harm."

There are variations of steps in PFA, ranging from eight to five or three, and a model designed for use in schools.[27] The American Psychological Association provides a hub with links to a range of tools.[28] Some of these tools like the WHO tool or the Australian Psychological First Aid Tool[29] are most suitable for using in disaster situations. Other bodies have simplified these steps to five or three for use in different types of situations, such as where people may be experiencing flashbacks.

For the sake of simplicity, the five-step process used by some agencies including the US NOLS outdoors framework[30] is used here. They are compatible with the "DO" and "DON'T" behaviours advised by agencies like the World Health Organisation, Public Health England and the Trauma Aware Schools programme.

[26] See Psychological first aid: Guide for field workers (apps.who.int/iris/bitstream/handle/10665/44615/9789241548205_eng.pdf)
[27] See Treatment and Services Adaptation Centre (traumaawareschools.org)
[28] See Psychological First Aid Resources; American Psychological Association (apa.org/practice/programs/dmhi/psychological-first-aid/resources)
[29] See Psychological First Aid: An Australian guide to supporting people affected by disaster (psychology.org.au/getmedia/c1846704-2fa3-41ae-bf53-7a7451af6246/red-cross-psychological-first-aid-disasters.pdf)
[30] See The 5 Components of Psychological First Aid; NOLS (blog.nols.edu/2017/05/22/5-components-psychological-first-aid)

The NOLS 5 Components of Psychological First Aid

This has been adapted from NOLS for situations where you may have people experiencing flashbacks, being retraumatised or in distress, after a major incident. It is intended to help people stay safe. The first key thing NOT to do is attempt to get them to relive their experience or talk in detail about what happened. If they choose to talk, fine. If they don't, do not push.

1. Create a Sense of Safety

Create a sense of calm as much as possible which helps the person overcome their immediate shock, flashback or "fight or flight" response. You may want to explain to them calmly that they are safe. Sometimes you may need to make an area safe (e.g. protect someone from scalding or burning or electrocuting themselves) while they are experiencing a flashback, for example.

2. Create Calm

Being calm yourself and enabling them to calm without forcing them is important. Using breathing techniques can help (e.g. a deep breath, counting to four then releasing) but speaking and acting calmly are the most important signals you can give, as well as helping someone find a calm and quiet space.

3. Create Self and Collective Efficacy

NOLS says that "Efficacy is your ability to produce a desired result." This can be more about helping someone care for themselves immediately to overcome a sense of helplessness that may come. The key thing is to support them and not take over. Give them space to help themselves. Listening attentively is a key behaviour. Giving advice isn't.

4. Create Connection

Listen to people, attentively, and this will create a connection. Use their name. Accept their experiences. Do not judge. This is as much about creating safety as connection.

5. Create Hope

This is NOT about saying "everything will be alright". It is about helping people come to the realisation for themselves that although the current situation may be very difficult, things can improve, and it may be helpful to then discuss whether there are realistic things the person can do to get appropriate help and support. It is important not to give advice or issue platitudes here. Time is not necessarily a great healer for everyone. Listen and when it seems right prompt "is there anything you could do to help you work through this?" or offer, "there are services other people with experiences similar to yours have found helpful … have you thought about asking your GP how to access them?"

It is also important to help people realise they are by no means alone, silly, stupid or unworthy of help. Lots of people experience trauma. Getting appropriate help when it's needed is an important step on the road to growing beyond it.

FaithAction

faithaction.net

Healthy Healing Hubs

Guild of Health and Saint Raphael

gohealth.org.uk/hhh