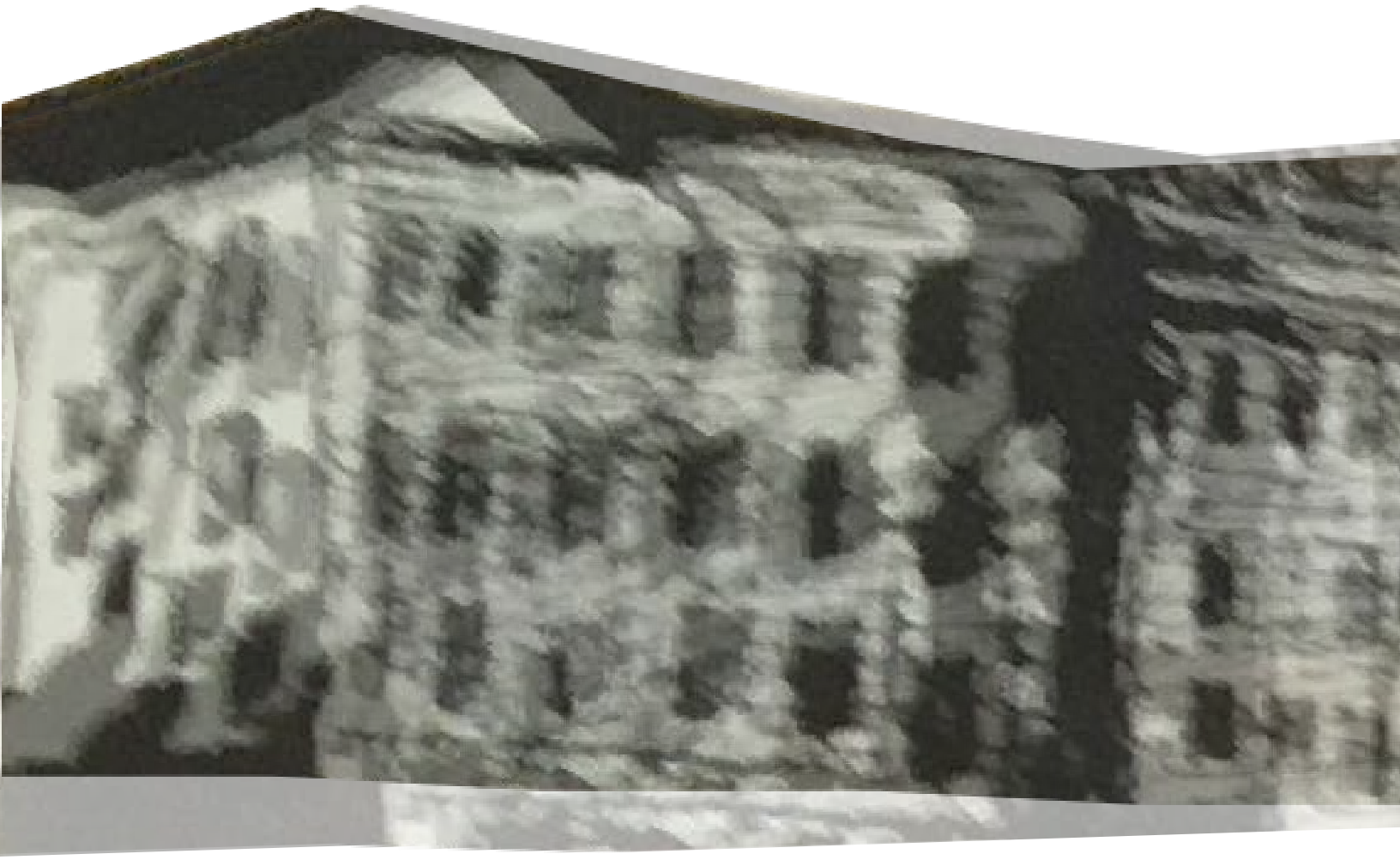
stories from the shadows



What these pages hold are stories. Stories collaged from pieces of different stories we lived and witnessed, as relief shelter workers, residential workers, social workers, housing support workers, supervisors, case managers, students, teachers. Moments that replay in our minds at 3 am. Voices and faces of people we once knew that compel us to seek different truths. Different from the ones we have been told and continue to tell ourselves and tell others about themselves so maybe we can fall back to sleep at 3 am. Maybe we can fall back to sleep after amending that case note so it better reflects agency standards. Maybe we can fall back to sleep after some recommended self-care routines. And trust us, we tried. But we don't fall back to sleep. We're still haunted by the things we saw, voices we heard, things we said, things we did, at 3 am or otherwise.

This is not a line drawn in the sand where we place ourselves on the good side. We were there on the dark side, under the shadows of what experts say about trauma and how we're supposed to help people and what we're supposed to report so we get funding and we keep our services open and we keep our jobs and our professional statuses, in places that are supposed to care for people who have lived through violence. Places like violence against women shelters, residential facilities for children and youth who have been neglected and abused, substance use treatment, mental health supportive housing programs. We were there as students and workers who took courses on non-violent crisis intervention (aka how to avoid being punched in the face) and signed up for training about PTSD and vicarious trauma and self-care with our co-workers and always made sure we were seated closest to the door when meeting individually with a client. We were there dutifully logging into central case management systems every 10 minutes of our activities and client encounters in every work day. And we were there as supervisors and teachers who facilitated emotion regulation and self-care exercises in team meetings and took part in eviction order procedures due to tenants/clients posing "safety risks to the housing community". For years we were there, and we did those things. For years we understood and enacted those things as self-protection and community-protection and universal precaution and the right things to do. That is one kind of truth.

Other kinds of truth, however, may come to light by questioning how the ingrained imperative to protect ourselves as workers in the professionalized care industry, and the whole body of knowledge generated for this purpose, are connected with the widely popularized, almost common sense beliefs that people who have experienced violence will become violent as a symptom of trauma (Pupavac 2002), and further, interacting with and listening to and supporting people who have experienced violence is traumatizing or harmful to workers (McCann & Pearlman 1990).

These were the truths we were taught to live by: Trauma is contagious. We must contain it. We must stop it from going around. We must make sure that people's symptoms are under control. We must separate children from traumatized parents or otherwise closely monitor the family because trauma is transmittable through generations. We must check in all the time so if people are not ok we can intervene immediately. We must also maintain professional boundaries, lest we become burnt out, fatigued, traumatized. We must follow established procedures. We must report our work to verify that we have met standards that uphold our professions. We fulfil our obligations to help traumatized people, proven by us meeting the quota of direct client contact hours per month/per week/per day, and during these hours we deal with people's demons and potentially violent behaviours and we become victims of harm.

the things we tell ourselves

the things we tell ourselves about others

the things we tell others about themselves

the things we tell ourselves

Incident Report

Name of _____

Resident Room No.: _____

Date/Time of Incident: _____Mar. 15, _____

Staff Reporting Incident: _____Social Worker-II___ **Witness of Incident:** ___Relief Worker _____

Summary of Incident:
Client was taken by two staff to Psychiatrist appointment. On the way home staff stopped for gas and offered client a chocolate bar. Upon leaving the kiosk, client insisted on being given the chocolate bar immediately. Staff explained he would have to wait until returning home. Client became aggressive, yelling at staff to give him the chocolate bar. Staff tried to de-escalate client. Staff explained that for safety reasons, client needed to calm down in order to ride in staff car. Client became increasingly verbally aggressive. Client became physically aggressive by punching car window.

Staff Intervention:
Staff tried to de-escalate client. Staff explained that for safety reasons, client needed to calm down in order to ride in staff car. After client punched the car window Staff placed client in two-person adult restraint. Client continued to yell obscenities and remained verbally aggressive while restrained. Staff informed client that if he did not stop fighting, then police would be called, at which point client stopped resisting. Client was then instructed to take a PRN. Client agreed to PRN. Staff instructed client to sit on ground while retrieving PRN. Staff did not feel safe transporting client within their own car, and phoned for the manager to come to transport the client home.

Was Emergency Services Contacted? Yes (No)
Police Badge No._____ Ambulance No._____ Hospital _____

Actions/plans to prevent a similar incident from occurring:
Staff recommendation to prevent further incidents is to contact Psychiatrist to increase client medications. As client was seen this morning by Psychiatrist, this should be completed within the next 72hrs. The second recommendation is to continue to ensure two-staff accompaniment with client to community appointments as client remains volatile and abusive towards staff. Funding for additional staffing must continue as client continues to present a safety risk towards others and self.

Staff Signature: _____ Date: 3/15/19

Manager Signature: _____ Date: March 16, 2019

A chocolate bar.

All that for a goddamn chocolate bar.

Like we don't get enough drama in this place already. Never a dull moment.

I just want a dull moment.

Yeah you just restrained the kid in a parking lot over a goddamn chocolate bar. And now you can't sleep and can't stop thinking about it.

Well we had to take him to the psychiatrist. He had no choice.

I have no choice.

So you bribed him.

I hate going to the psychiatrist

he never asks me about my artwork

Does anyone ever ask him about his artwork? About what he likes? Or wants? Or needs?

He came back from one of those Psych sessions saying he hurts people when he's angry because he was abused and his parents are bad.

Where did he get that from? Who told him that? How would you know if they were bad people? Are you a good person?

YOU PROMISED

I made him sit in the dirt in the parking lot for a goddamn chocolate bar.

If only he could wait 10 minutes to get home! We're supposed to "model boundaries". He needs to work on impulse control. I'm just following the treatment plan. He clearly can't control himself. I don't know if I'm safe. He probably doesn't feel safe either. We need more funding.

that's NOT FAIR. I followed the rules

What's more funding going to do, exactly? He needs real help. And you know the rules don't even make sense.

I saw how scared he looked when we told him we won't take him home if he doesn't stop yelling or we're calling the police.

He probably saw how scared you were of him. So scared you had to restrain him. He probably just wants people to like him, you know. Like everyone else. Like you.

Just doing our jobs. It's the protocol. We were in community. If anyone gets hurt we would be responsible. We had to do it.

If you totally believed that you'd be asleep by now.

What's done is done.

No it's not. You told him he could trust you and you still promised him that chocolate bar.

The things that make us ask how we got here and where

do we go

from here

ASSIGNMENT 9:18 AM DUE FRIDAY APR 1 11:30 AM

In-Class Discussion #11

Now that we're at the second last class of the semester, what are your takeaways? What stood out to you about trauma-informed care? How might this learning inform your work with people going forward?

3 DONE

9 NOT DONE

HopefulPetunia416 10:20 AM

The biggest learning for me this semester was about vicarious trauma. I had never thought about this before. Hearing my professor tell me that I will be harmed by my clients' trauma was eye-opening.

Anonymous Participant 10:21 AM

I agree with @HopefulPetunia416. I feel like I need to be on guard when I enter the field, because I have chosen a profession where I will be traumatized by my clients. People will come to me with their stories of abuse, and it's like I will also then experience abuse. It's like they pass this abuse on to me and infect me with trauma. This wasn't something I thought was possible.

Prof_K 10:28 AM

Thank you both for your candid reflections. Let's take a moment - How did we shift away from understanding the perpetrator of violence as the person causing harm, to the survivor of violence as the person causing harm to us?
What's our position of power in relation to the client? Who is positioned to be harming whom? Are we minimizing our clients' experiences if we equate hearing abuse/assault as the same thing as being assaulted? What happens when we claim other people's stories as ours?
If/when we misappropriate/misuse the words "trauma" and "abuse", what would that do for people who have experienced violence and abuse?
How can we work in strengths-based and empowering ways with folks we're supporting, if we see them as / believe them to be harming us? Happy to talk more after class if you'd like.

Reply

_student_204 10:31 AM

now I know I will need to make sure that I eat healthy and regularly exercise. My family and I have been through a lot and I will need to take care of myself and be careful about how compassionate I am toward others, because otherwise I will have compassion fatigue.

Prof_K 10:39 AM

Thank you for reflecting on where you're at with this and the experiences you bring. I'm wondering... How can we be aware when our experiences emmesh with that of the other in our perception? How can we begin to unpack the entanglements between our experiences of violence or oppression with those of the other?

Reply

A day in the life of a good robot

in the care industrial complex

Time	Input	Capacity	Output	Client
08:00	Coffee 250 ml.	60%	Travel-public transit - 64 minutes	N/A
09:04	--	50%	Counselling Session w/11452 - 58 minutes	Direct face to face
10:02	--	22%	Accompaniment w/09874 - 121 minutes	Direct face to face
12:03	Coffee 125 ml.			
	Gluten free cookie x 2	28%	Team meeting - 64 minutes	Indirect
13:07	--	19%	Supervision - 50 minutes	Indirect
13:57	Sandwich, veg, at desk	35%	Activity log - 42 minutes	N/A
			[mandatory self-care implemented]	
14:39	--	29%	Crisis intervention w/08226 - 22 minutes	Direct face to face
15:01	--	12%	Mindfulness group facilitation - 94 minutes	Direct face to face
16:35	Coffee 350 ml.	43%	Home visit w/10587 - 46 minutes	Direct face to face
17:21	--	15%	Phone session w/08766 - 24 minutes	Direct non face to face
17:45	Grapes from Margaret	36%	Case consultation - 56 minutes	Indirect
18:41	--	30%	Travel-public transit - 72 minutes	N/A
19:53	Bath, with bubbles	45%	Session notes - 92 minutes	Indirect
			[mandatory self-care implemented]	
21:29	Dinner, Door Dash	54%	CE-PTSD training video - 60 minutes	N/A
22:29	Wine 125 ml.	32%	--	N/A
01:39	Sleep	4%	--	N/A
02:04	Warm milk 200 ml.	2%	Session notes - 12 minutes	Indirect
2:16	Sleep	1%	--	N/A

-----End of Record for 09/07/2018-----

déjà vu

CRH Community Living - MH Supportive Housing
Intake Assessment

Application no.: 811054 - rec'd 12/04/2041
DOB: 02/18/2022

Unit requested: 2 BR for 1 adult (applicant) and 2 children

Housing history: Applicant residing with mother for the past 6.5 years. Has 2 children, both removed 7 years ago due to DV and addiction. Girl (10) returned to applicant 4 years ago, and boy (8) 3.5 years ago. 2 adults and 2 children residing in 2 BR rental unit (underhoused). No arrears. No prior evictions on record.

Bio-psycho-social assessment: Applicant discloses DV and IPV before moving in with mother. Teenage pregnancy. Mother divorced when applicant was 2 yrs old due to IPV. Applicant employed part-time at convenient store. Applicant on opioid replacement regiment (methadone) for past 5 years. Child Welfare Service records show compliance with abstinence program, parenting skills training and group counselling. CWS file closed in May 2046.

Pre-existing condition(s): Intergenerational Trauma - Code F43.12

Decision: Conditional Offer - Code F43.12
1) Continuing Support Program: 2x monthly meetings (home or office) with assigned case manager
2) Enroll children in MH Early Prevention/Intervention Program
3) CWS attestation letter confirming applicant's storage and use of methadone in the living environment are safe for the children

Assessment date: 03/05/2048
Assessed by: Housing Worker ID 45907

For Office Use Only

Housing offer sent: 811054 - 03/10/2048
Move-in date: N/A - Offer declined by applicant (reject conditions)
SHCAS note: Refused offers 2 of 3*

*at next refused offer remove applicant from waitlist and notify to reapply.

Things we tell ourselves about an other

involving an incident at 3 am.

Safe Haven Women's Shelter

Client Discharge Form

Client Name

Client Number

0244338

Date of Admittance

03/09/2021

Date of Discharge

03/22/2021

Reasons for Admittance

Client arrived at shelter two weeks ago. Client indicates she is homeless and fleeing from abusive partner. Client arrived at shelter with several bruises visible on face and arms. Staff advised seeking medical attention, client refused. Client disclosed diagnosis of depression and anxiety, however client is not taking any medications.

Type of Discharge

- ○ Completed and transferred to housing
- ○ Incomplete and transferred to housing
- ○ Completed and remains homeless
- ● Incomplete - dropout or refused service

Housing Status at Discharge

- ○ Permanent housing
- ○ Temporary housing
- ○ Homeless
- ● Unknown

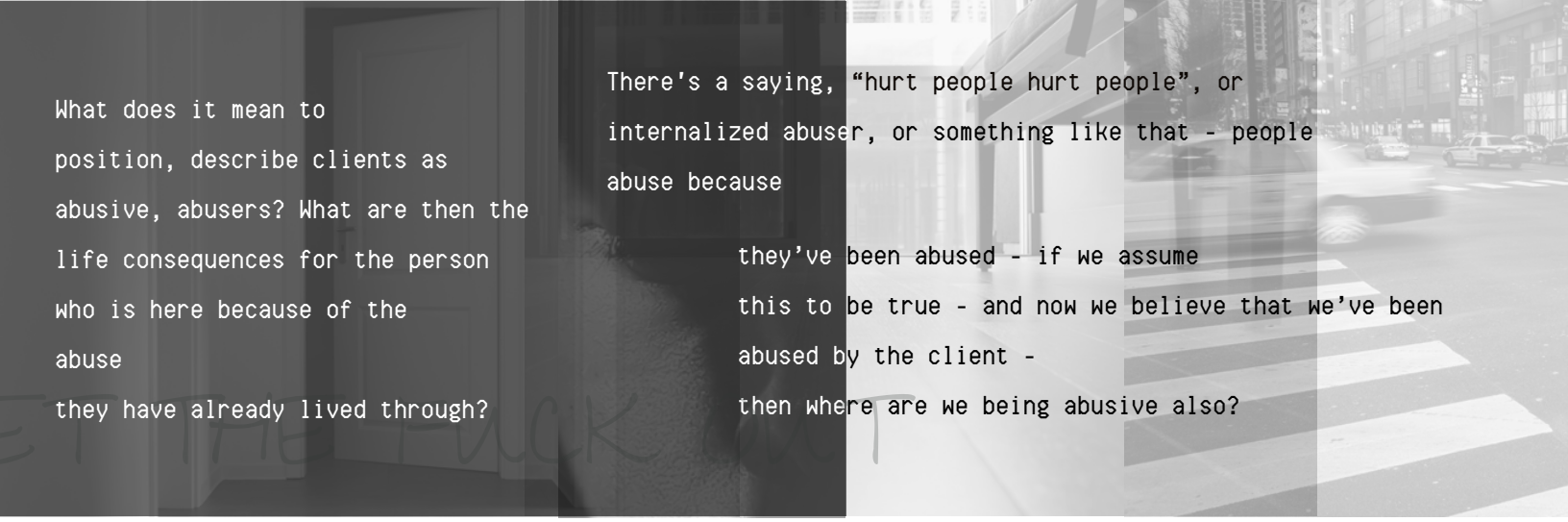
Discharge Summary Comments

At 3am overnight staff was conducting regular scheduled overnight bed checks to maintain the safety of the shelter residents and staff. For no reason at all client began yelling at staff when staff entered their room to see if they were sleeping. Staff explained the reason for the bed check. Client quickly escalated, yelling at staff to “get the F#$% out” and yelling profanities. Staff maintained healthy boundaries by informing client that residents who were abusive towards staff would be discharged. Client threw items of clothing towards staff and continued to be abusive by yelling at staff to leave them the “F#$%” alone". Staff phoned on call for support. On call instructed staff to discharge client once day staff arrive on shift.

Cancel

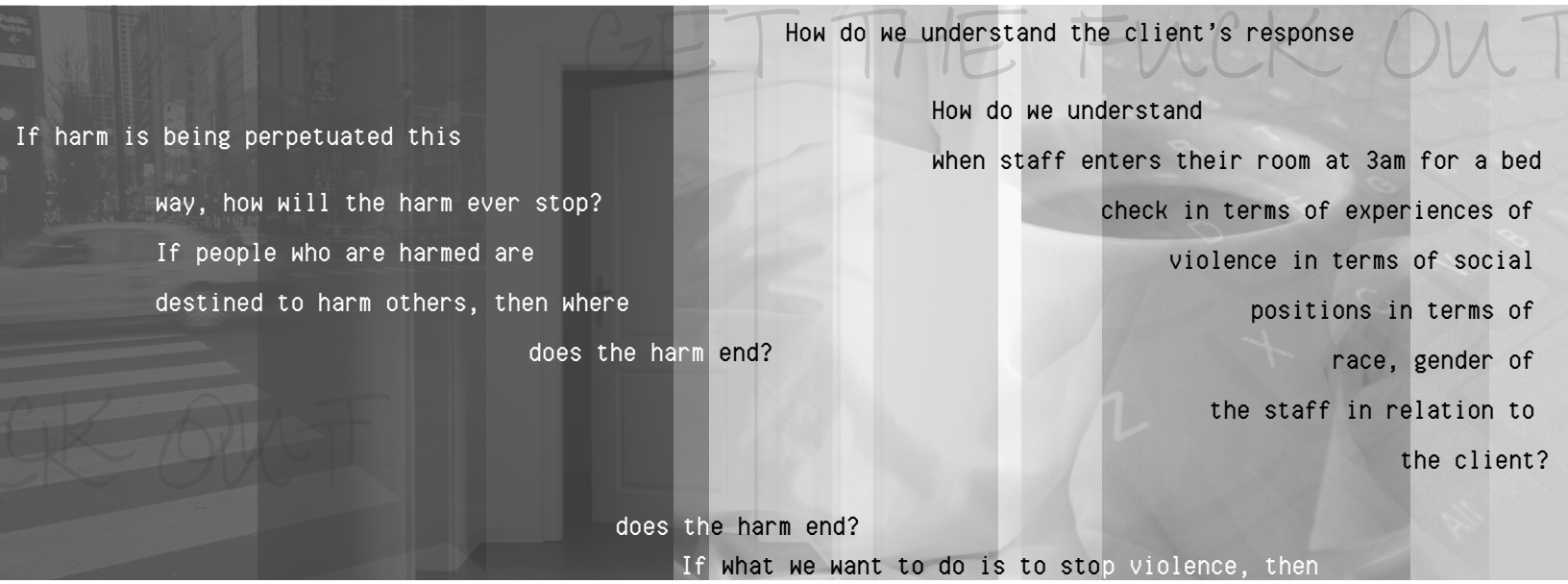
SUBMIT

Things we ask ourselves at 3 am.



What does it mean to position, describe clients as abusive, abusers? What are then the life consequences for the person who is here because of the abuse they have already lived through?

There's a saying, "hurt people hurt people", or internalized abuser, or something like that - people abuse because they've been abused - if we assume this to be true - and now we believe that we've been abused by the client - then where are we being abusive also?



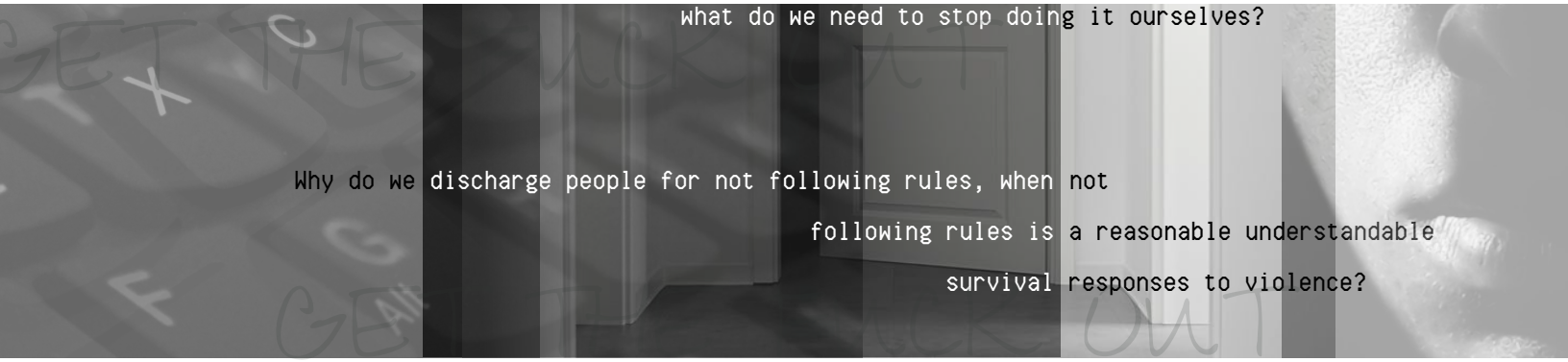
How do we understand the client's response when staff enters their room at 3am for a bed check in terms of experiences of violence in terms of social positions in terms of race, gender of the staff in relation to the client?

How do we understand

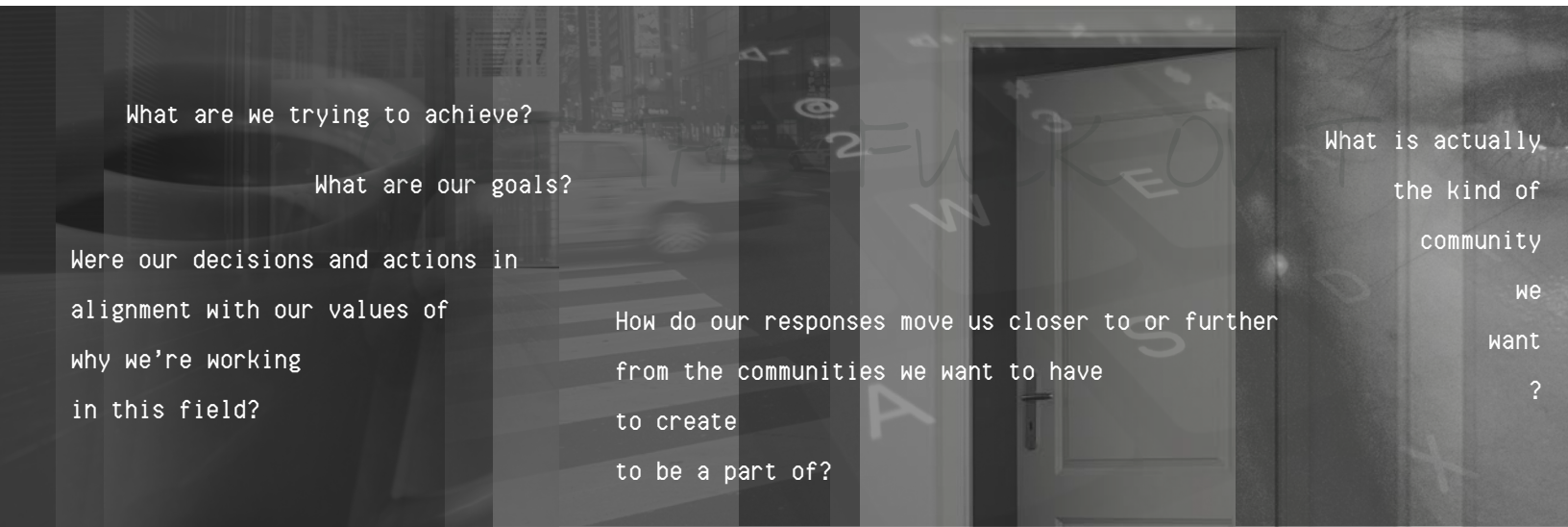
If harm is being perpetuated this way, how will the harm ever stop? If people who are harmed are destined to harm others, then where does the harm end?

does the harm end?

If what we want to do is to stop violence, then what do we need to stop doing it ourselves?



Why do we discharge people for not following rules, when not following rules is a reasonable understandable survival responses to violence?



What are we trying to achieve?

What are our goals?

Were our decisions and actions in alignment with our values of why we're working in this field?

How do our responses move us closer to or further from the communities we want to have to create to be a part of?

What is actually the kind of community we want?

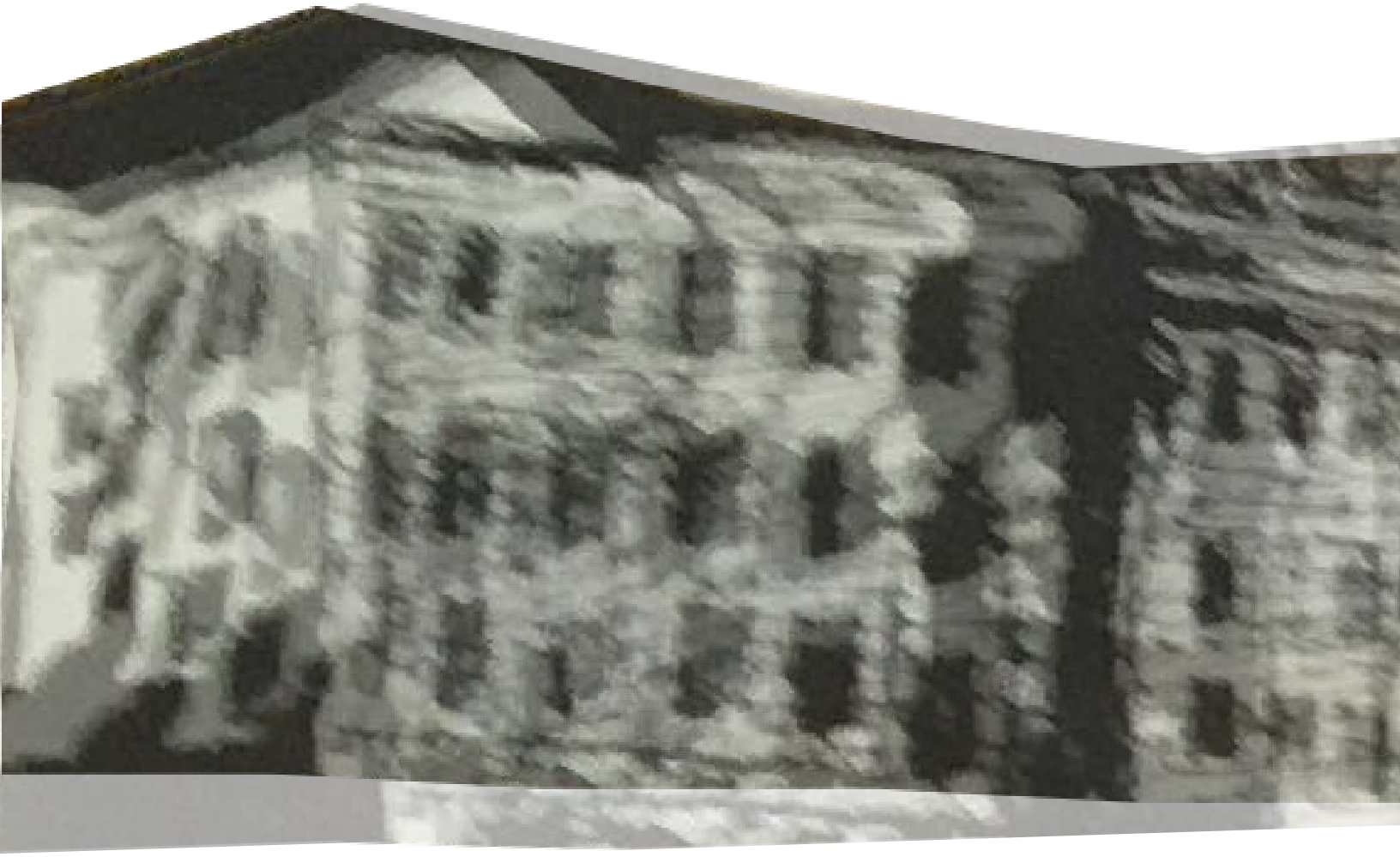
We are still here, under the shadow of these truths, albeit in different ways now that we have left these workplaces and are no longer fully immersed in these spaces. This distance afforded us the privilege of having other kinds of space, such that at 3 am we find ourselves awake looking for the sunny spots amidst the shadows, at different angles, from different ways of seeing.

That is not to say that workers are not impacted by stories of violence, or that self-protection and self-care aren't the right things to do for workers in the professionalized care industry in any given context. The things that keep us awake, however, have compelled us to turn our gaze back on ourselves.

What do these stories about trauma, about workers being harmed by clients' trauma stories, tell us about us? That we are passionate helpers selflessly braving people's dangerous demons, ready to be martyred for the divine cause of rescuing people from themselves? This seems to follow the roots of North American, Eurocentric social work as religious charity (Chapman & Withers 2019). But we don't really sacrifice ourselves, do we? Otherwise we wouldn't care less about vicarious trauma.

What then, do these stories tell us about the people we encounter, the people we work with, the people we claim to help? Did we call people to check in because we need to fill those direct client contact hours, or did we need to make sure that people are not doing anything dangerous? A bit of both? Either way, did it not vilify the parts of people that have experienced violence, and did it not altogether dehumanize the person? What actually did our watching, our "checking in", our surveillance do to help improve people's wellbeing or quality of life? When we had a seat in spaces where we exercised power to decide whether someone can have housing or not, can access support workers or not, can access resources or not - where we tell stories about people and frame them in trauma in order to maintain our funding, our programs and our jobs - who is in the position to cause harm to whom? Who is in the position to make who sick?

In the meantime, our gaze and our efforts are fixed on the people we work with as threats, or on our own wounds of exhaustion and despair as victims. And all the while the systems and operations of surveillance and institutional hierarchies and social control and



subjugation from the days of the asylums -- things all around us that produce suffering and helplessness and hopelessness, that position us as agents of the states whose work repeatedly undermines the skills and knowledges that people have used to survive and meet their needs before ever meeting us, that make the lives of those who are deemed different or deviant precarious and unlivable through widespread colonial violence and a multitude of interlocking oppressions -- thrive quietly in the shadows, seldom entering our awareness. These are the things that keep us up at 3 am. Not only the stories of violence that we hear from people we work with, but more insidiously the violence they continue to experience when they came to us for help. The systems that perpetuate violence and our roles in them.

Who is in the position to cause harm to whom? Who is in the position to make who sick?

Between the lines in these collages of memories and stories, there are also sunny afternoons where we sat with our co-workers sharing grapes, complaints, feelings, photos of grandchildren, recipes, pet videos, and then logging in those unproductive hours as “client-indirect” because we mentioned one tenant by name. There are persistent, insistent, resistant voices to ostensible help by those positioned as "clients". There are hours spent punching a flipped mattress and pillows with a young person while refusing to apply restraints even though the protocols warrant it. There are unlogged home visits to investigate a malfunctioning TV, or help someone wrap bandages around their injured hand, knowing that these were outside our “professional boundaries”. There are logged hours of “working on client goals” that were actually spent together in silence, allowing tears of grief, loss and anger to flow.

We are never fully outside of the reach of the narratives that perpetuate harm and position us as victims. But maybe one way of carving out a different space is to question whether a truly caring community can ever exist within the boundaries of the professionalized care industry. We ask ourselves what kind of community we want to create in its stead. Perhaps such a community will find opportunities to grow by extending the time we are there for each other, and expanding the spaces for human dignity, connections, and resistance against institutional subjugation and violence, in ways we have been taught not to.

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Art & text by

Kathryn Mettler https://www.linkedin.com/in/kathryn-mettler/

Patricia Ki https://mappingcare.art

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